The RHODE ISLAND MEDICAL JOURNAL

VOL. XL JUNE, 1957 NO. 6

UTERINE CANCER

A Report of the First 2,000 Cases of the State Cytology Program for Uterine Cancer*

HERBERT FANGER, M.D., Y. S. SONG, M.D., AND THOMAS H. MURPHY, M.D.

The Authors. *Herbert Fanger, M.D., Director-Pathologist, Institute of Pathology, Rhode Island Hospital; Y. S. Song, M.D., Associate Director, State Cytology Program; Thomas H. Murphy, M.D., Director of Cancer Control, Rhode Island State Health Department.*

Introduction

THIS is a progress report on the mass screening project for genital tract cancer in the women of Rhode Island. We are studying the incidence of clinically unsuspected cancer in the genital tract by means of vaginal exfoliative cytology. The details of the program have been described in the September, 1956 issue of the RHODE ISLAND MEDICAL JOURNAL and in talks to hospital medical staffs. This project is supported by the U. S. Public Health Service and is approved by the Rhode Island Medical Society, the Rhode Island Pathology Society, and the Rhode Island Chapter of the American Cancer Society. There are similar programs in other parts of the country.

Two thousand patients have been examined in the first three months of the program. The daily volume of tests is progressively increasing, so that we are now averaging 80 cases per day. We are examining vaginal aspiration smears and cervical scrapings from each case. Thus, double the number of slides are examined than in the usual cytology study.

Classification of Smears

The project is using the following classification system as recommended by the U. S. Public Health Service:

01 *Unsatisfactory*
Insufficient material present
Smear too thick for interpretation
Presence of too many blood cells
Smear dried before fixation

10 *Negative*
No abnormal cells seen

20 *Atypical*
Abnormal cells due to inflammatory reactions which would require further study by repeating smear in 1, 3, or 6 months

30 *Questionable*
Suspicious, but inconclusive—immediate repeat and biopsy, if persistent

32 *Cells present* suspicious of carcinoma *in situ*

33 *Cells present* suspicious of invasive carcinoma

40 *Conclusive evidence* of malignancy — squamous or adenocarcinoma—few cells seen

50 *Conclusive evidence* of malignancy — tumor cells are frequently rather than sparsely present

Additional smears are requested on all unsatisfactory smears containing too much blood or too many leukocytes, as well as in all cases reported as atypical or questionable.

Results

A summary of the results of the first 2,000 cases based on reports to the clinicians is given below:

	Cases
Positive and Suspicious Group	40 (2.0%)
*Intraepithelial carcinoma of the cervix	17
*Marked atypical hyperplasia	3
*Squamous cell carcinoma of the cervix	2
*Squamous cell carcinoma of the vaginal wall	1
*Adenocarcinoma of the uterine fundus	1
Biopsy negative (punch)	1
Biopsy recommended but not yet received	11
(Inadequate Biopsy)	3
Repeat smear recommended	4
Atypical Group (Inflammatory Change)	152 (7.6%)
Unsatisfactory	135 (6.8%)
Negative	1,673 (83.6%)

*Proved by biopsy.

*Rhode Island Women's Cancer Cytology Survey, Rhode Island Hospital, Unit K, Providence, Rhode Island.

continued on next page

Discussion of Results

In 35 out of 2,000 cases, the cytology diagnosis was positive or suspicious of cancer and biopsy was recommended. The majority of specimens were examined in our histology laboratory where serial sections were made in order to confirm the cytologic diagnosis. Frequently the lesion was minimal, not grossly apparent, and only demonstrated as a microscopic focus by means of the serial section technique. Approximately one half of the specimens examined were cone biopsies, and the rest were cervical punch biopsies, usually from four quadrants. Two biopsy specimens were destroyed by electrocauterization.

Intraepithelial Carcinoma Confirmed

There were 17 cases of intraepithelial carcinoma confirmed by tissue study, 8 of which were found in a group of young women under 35 years of age. Nine other cases occurred in women under 45. The youngest woman was 28 years of age and had two children. The cervix showed no gross lesion that might be suspicious of cancer. Three cases were borderline, showing marked atypical epithelial changes, but not sufficient for a diagnosis of malignancy. In general, we strongly recommend cone biopsies for these cases which grossly show no abnormality. This is the only way adequately to examine the entire endocervical tissue. By serial sectioning all of the tissue, a complete search is made for the small focus of carcinoma which might otherwise be missed.

Squamous Cell Carcinoma Confirmed

There were two cases of invasive squamous cell carcinoma of the cervix. One case was suspected clinically by the appearance of the cervix, while another was diagnosed as cervical erosion. Physicians are advised to submit smears from patients with lesions suspicious of malignancy to their hospital laboratory, since the specimens from these cases are of no value to this project. If smears are collected from women with marked gynecological complaints, then the statistics of the incidence of clinically unsuspected cancer will be inaccurate and will defeat the purpose of the project.

Miscellaneous Carcinomas

One case of adenocarcinoma of the uterine fundus and one case of squamous cell carcinoma of the vaginal wall were both confirmed by our study and clinically suspected.

False-Negative or False-Positive Cases

The number of cases is too few for statistical significance. We have confirmed the cytologic diagnosis in 21 out of 26 cases in which biopsies were obtained. In 3 cases, the biopsy revealed an atypical hyperplasia, in 1 case a punch biopsy was reported as negative, and in 1 case the biopsy was inadequate. The latter two cases represent inadequate biopsies and follow-up will be important.

It is too early to evaluate the number of false-negative cases. In order to determine its incidence, it will be necessary to repeat the smears on these women annually, for at least 3 years. The reports sent by the doctors to the patients tell them of the need for an annual repeat smear. It is hoped that the physicians will emphasize this point.

Method of Reporting

All of the reports are sent to the physicians. None is sent to the patient directly. The report uses the classification previously described. Repeat smears are requested in the cases diagnosed as atypical or questionable. Biopsies are recommended on cases diagnosed as suspicious or positive for cancer. A diagnosis of malignancy can be made only by histologic examination. The cytology examination can indicate only the cases which should be biopsied. Recommendations for therapy are never indicated on the basis of cytological findings alone. Occasionally, physicians and patients have been alarmed by the report of "atypical." The atypicality is usually due to an inflammatory reaction, and we recommend repeating the test in 1, 3, or 6 months, depending on the degree of atypicality. It is highly unlikely that neoplasm is present, and we recommend a repeat smear in order to study inflammatory cell changes and to insure that a more serious abnormality is not present.

Source of Smears

Most of the specimens are sent from doctors' offices. Approximately, 210 physicians are actively participating in this project. Physicians are urged to collect specimens from women having no clinical signs suspicious of malignancy. If the smears are collected from symptomatic patients, then the statistics of the incidence of incipient uterine cancer will be inaccurate. On the whole, the physicians have been cooperative in this respect as shown by the large number of cases of carcinoma *in situ* which have been detected.

SUMMARY

1. The goal of this mass screening project is to determine the incidence of clinically unsuspected cancer of the genital tract in the women of Rhode Island.
2. During the first three months of operation, specimens from approximately 2,000 women were examined.
3. In this relatively short period of time, 17 clinically unsuspected cases of cancer of the cervix were discovered through this survey and confirmed by tissue study. In addition to these, four

concluded on page 332

RETROSPECT AND PROSPECT — 1957*

CHARLES L. FARRELL, M.D.

The Author. *Charles L. Farrell, M.D., of Pawtucket, Rhode Island; President, The Rhode Island Medical Society; Consultant, U.S. Department of Health, Education and Welfare; Member, Board of Directors, Rhode Island Medical Society Physicians Service; Past President, Conference of Presidents and Other Officers of State Medical Associations, of the Association of American Physicians and Surgeons, and of the Pawtucket Medical Association; Past Secretary, Rhode Island Board of Examiners in Medicine; Recipient of Degrees in Medicine, Dentistry, and Pharmacy.*

As I ADDRESS YOU formally for the last time in my official capacity as president of the Rhode Island Medical Society, I would like to leave for posterity an erudite address which could take its place with the presidential addresses of my illustrious predecessors in office. I am, however, so deeply concerned with the changing medical times and the urgent necessity for close attention to the more mundane aspects of our medical practice, by each and every member of this Society, that I will instead review for you some of the events of the past year and evaluate the potentials of the future.

We are fortunate indeed to own our present Medical Society headquarters and Library at a time when many other societies are in the process of financing the construction of similar facilities.

It is important to remember however, that the upkeep of this property is increasingly expensive and provision must be made yearly for repairs, modernization, and improvements if we are to avoid heavy assessments later for lack of constant attention to the Library building. In this connection I want to call to your attention that your Trustees have this year made several important changes which will be completed during the summer months. A new and more comfortable reading and conference room will be created in the basement where new lights and bookcases have already been installed. The Executive Secretary's office will be modernized and improved facilities are planned for the office staff, with new equipment designed to give you improved service and to keep you informed on the changes and events that affect you professionally and economically.

Your Society has, through special bulletins and notices, kept you posted on malpractice insurance, polio, rheumatic fever, Medicare and many other aspects of medical practice throughout the year, and it will continue to be alert to keep you informed and solicit your reactions, in order to serve you to the best of its ability.

Your library reference services continue to fill a vital role in the affairs of medicine as well as the community at large, and continue to be well patronized by the profession and the public. Our RHODE ISLAND MEDICAL JOURNAL has had another successful year and is widely read, judging by the requests for abstracts and reprints that come from the far corners of the earth.

Last year we were saddened by the death of one of our most colorful personalities, and the long-time Editor of our Medical Journal, Doctor Peter Pineo Chase. Doctor Chase was famous far beyond the confines of Rhode Island for his ability as a surgeon and also as a writer of note and an authority on Doctor Johnson. His homely wit and his pungent aphorisms will long remain in our memory, and we are pleased to note the publication of his book this week titled YOUR WONDERFUL BODY.

In the field of medical science the Society continues to use its influence and facilities for the advancement of the public health. As an example, I cite the recent polio immunization campaign of our Society which received national acclaim and commendation from the press and the American Medical Association. If anything, the campaign may be said to be too successful in that we evoked so much interest and support that vaccine supplies quickly became exhausted, although previously we were told there was a surplus. I have been in communication with the American Medical Association and the U. S. Public Health Service and have been assured that supplies are being released to meet our needs in the immediate future.

Another project, about which little was said publicly in order to prevent needless alarm, was the activity of the profession when there was an increase in scarlet fever and rheumatic heart disease cases in February. Your Society alerted the pro-

continued on next page

*Presidential Address delivered at the 146th Annual Meeting of the Rhode Island Medical Society, at Providence, Rhode Island, May 1, 1957.

fession and provided full and prompt cooperation to the State Health Department, the Rhode Island Heart Association, and the U. S. Public Health Service for the taking of cultures, the administration and distribution of penicillin to school children and contacts, and the special study of certain schools where the incidence was highest. It is interesting to note that in these special school studies only seven parents out of several hundred refused to participate in the special program. The U. S. Public Health officials were amazed at the speed and efficient cooperation of your Society and the medical profession of Rhode Island and they were generous in their praise for our assistance.

Unity in the Profession

Doctor Frank B. Cutts, the immediate past-president of this Society, called attention in his presidential address last year to the need for *unity* in the profession, and he deplored criticism without the attempt to reform. Doctor Albert Jackvony also pointed out in his annual address in 1953 that only a "minority of the physicians realized the full extent of the activities of the Society." Doctor Charles J. Ashworth, in his address in May, 1951, said "The value of a better understanding of the socio-economic factor as an integral part of medical service today is of paramount importance—no less a task is ours in practice, to arouse a broader social consciousness in the individual, ever mindful that medical practice is no longer, if it ever was, a private enterprise, but a public responsibility of the highest order." Therefore I hope you will forgive my repetition of this theme as I attest to its importance after serving as president this past year.

A very brief report of some of the highlights of our public service activities during the past twelve-month period warrants reporting to you.

The Society offered its cooperation to the Department of Motor Vehicles on the problem of the handicapped driver. A nine-man committee is now working with the department and the registrar on this problem.

The legal counsel of the Society and the Committee on Highway Safety examined in detail the Alcometer bill introduced in the General Assembly and felt that with its latest corrections it was a good bill, with adequate legal and medical safeguards.

While on the subject of legislation I would like to remind you that each year a new attempt is made to amend the Basic Science Act in order to qualify by legislation some person, or group of persons, who could not otherwise be considered to have had the minimum education now recognized as essential in order to safeguard the public from incompetent and inadequately trained practitioners. This is one area where constant vigilance is necessary in the interest of public welfare.

One of our most far-reaching and exhaustive committee activities was the work of the Chapin Hospital Committee which carried over from last year. This committee spent many hours at meetings, interviewing witnesses, searching files and records and getting expert opinions and legal advice in order to do a thorough job. The Society paid expenses of over one thousand dollars for this committee. I consider this to be a considerable sum of money for your organization to expend in the interests of the health problems of our citizens. THE PROVIDENCE JOURNAL made the committee report the subject of two full-page editorials.

Before leaving the subject of committees I want to pay special tribute to the activities of Doctor Marshall N. Fulton and his committee on Scientific Arrangements for the very excellent programs they arranged for both sessions of the Society this year.

I also want to pay tribute to the high caliber of medical care in this state, as well as the constant expansion of medical activities on the part of the profession and the ever-increasing and steadily improving hospital facilities at our disposal. The type of medical care available to the citizens of Rhode Island is the equal of any given at the larger medical centers of the country. We have modern hospitals and special clinical facilities for the care and treatment of brain, heart, and lung surgery, as well as special diagnostic equipment for unusual tests.

The high cost of hospital care continues to disturb us. Thirty years ago the rate for a ward bed was three dollars a day. Now it is from $13. to $16. When one envisions the rapid and almost phenomenal progress of medicine, and of hospital care, it is understandable why costs have risen. Blue Cross plans have helped materially to lighten the individual burden, but not as completely as desired. In the very near future I hope that the Rhode Island Medical Society Physicians Service will be able to offer a Major Medical Expense Coverage that will be helpful to patients and hospitals alike. One important aspect of hospital aid that has not received the attention from the public it deserves is more voluntary donations from the individuals, business, and industry. I quote from the presidential address of Doctor Herman A. Lawson in May, 1952: "There is too much emphasis and exaggerated importance given to the 'drying up' of philanthropy, the disappearance of those wealthy benefactors who in other days were willing, and able, to give large sums which supported our hospitals and prevented a deficit. The support should now come from the many people in the state who could make individual small contributions."

That the need for additional public support is acute is demonstrated by the fact that for the past two years bills have been introduced in the State Legislature asking for partial reimbursement to

the Public Health Nursing Associations for bedside care rendered by the nurses. If we are to avoid ever-increasing hospital and nursing deficits we must continually improve our voluntary prepayment plans and increase our voluntary contributions to health and welfare organizations.

The State Sanatorium

Some months ago I appointed a committee to review the utilization of beds at the State Sanatorium at Wallum Lake. The committee made an exhaustive study of the problem and recommended that the Sanatorium admit nontuberculous cases of chest diseases, and also establish an asthmatic unit for children. Legislation to permit this change was introduced in the General Assembly.

The Society expressed concern that Wallum Lake patients are sent to hospitals in Norfolk County and Cambridge, Massachusetts, for lung surgery that can and should be performed here. Some years ago when such surgery was in its early stage of development and there were few fully qualified chest surgeons available, your Society accepted such an arrangement as being in the best interests of the patients. As time passed, however, and as qualified surgeons developed in this state, it became obviously unfair to subject Rhode Island patients to additional travel to another state and to require their relatives and blood donors to make these trips also.

In addition to this, the state has had to pay thousands of dollars of tax money for services which might be more economically and just as efficiently administered in Rhode Island. Patients who have nontubercular chest diseases are being operated on in our local hospitals constantly and this same service should be available for Wallum Lake patients also. A committee of the Society has demonstrated that there are surgeons and hospitals prepared to take on this responsibility, but we have been unable to interest the Department of Social Welfare in making the change. The director of Social Welfare expresses his interest, and obviously his approval, but the Superintendent of Wallum Lake prefers the present arrangement. In the meantime the proposal is "under study." We should not be impatient with slow and careful consideration of all aspects of such proposed changes, but we should recognize that undue delay in providing for our tuberculosis patients the same services that are constantly utilized in our hospitals at the present time for nontuberculosis chest cases, is not in the public interest. It is imperative that this problem be under constant study.

The Medicare Program

A new problem has arisen this year—*Medicare*. This is the result of the passage by the Congress of the United States of Public Law 569 which permits medical care for dependents of the uniformed services in civilian hospitals. It is not an insurance program and it is not geared to income levels; it affects the dependents of all uniformed personnel from enlisted men to generals and admirals. The hospital and medical care "Schedule of Allowances" to be paid by the government is provided through contractual arrangements between the Department of Defense and the various Blue Cross-Blue Shield plans or insurance companies.

Last fall this problem was presented to us with the request that all details be completed and the plan put in operation by December 7, 1956. One meeting at American Medical Association headquarters in Chicago was arranged with a Navy Task Force to brief the Society officers on this subject. Subsequently we journeyed to Washington and found a very different concept of the plan than the one on which we had been previously briefed. Since Rhode Island had no previously established fee table it was necessary to prepare one which would be representative of the proper fees for the medical-surgical care in this state. I therefore quickly assembled a group representative of all of the specialties within the profession. I kept the committees limited in personnel and chose them from men within the greater Providence area as "time was of the essence," and I also asked them to canvass their colleagues to be certain that they would reflect the thinking typical of their specialties. Several small group meetings were held and three large meetings followed; thus a fee table was born with the usual pains of accouchement. It was then subjected to all kinds of operative procedures before final acceptance. The House of Delegates authorized this committee to speak for the Society in this government proposal.

In our negotiations with the Army we learned that it had already decided on what it thought the proper fees for Rhode Island, and that they were for a "low income group" as we were supposed to be in a distressed area economically. I quoted statistics, sent clippings from the financial section of the SUNDAY JOURNAL, reports from the Rhode Island Development Council, etc., but the Army gave us no contract even though we revised our fees as they suggested to conform with the changed conditions proposed to us in Washington, and which varied from our original concept of the plan as explained to us in Chicago. We offered to negotiate some of the more common procedures but this offer was ignored. So, by December 7, the Army offered Rhode Island physicians the Army's version of what medical service was worth in Rhode Island.

It is the privilege and right of every doctor to decide for himself whether or not a fee offered by

concluded on next page

a third party should be accepted as full payment for his professional services, particularly when no contractual obligation exists to provide otherwise. It is our contention that the law does not prohibit patients from paying their doctors any difference between the Army allowance and the prevailing fees established by the Society, *if* the patient is able and willing to do so. In the application of this Act the General in charge insists that the Army allowance is to be *full* payment even if insurance sources exist to pay a balance remaining. The Army will pay *nothing* for the patient's medical care unless the doctor accepts the Army fee as *full* payment, although the patient may occupy the most de luxe hospital accommodation without forfeiting any claim on the Army's allowance for hospital care. The subject of *fees,* though relevant, is *not* of prime importance, but the principle involved is vitally important.

I commend to your attention the editorial published in the RHODE ISLAND MEDICAL JOURNAL for January, 1957 on the *Erosion of Medical Liberties,* and the December, 1956 report of the negotiating committee of the District of Columbia as reported in the ANNALS OF THE DISTRICT OF COLUMBIA.

Amendments to this federal law have already been proposed in Congress to liberalize the benefits to include retired personnel, and others. Do you think that you can accept limitations of practice and Army dictation while your patient is in service, and then have him agreeable to the removal of these limitations on his return to civilian life? Time does not permit me to fill you in on all the details and complexities of this problem. Your House of Delegates is fully informed and has taken action designed to evolve a satisfactory solution. I call this matter to your attention primarily to again emphasize that "Eternal Vigilance is the Price of Safety." Is this socialized medicine by the back door? Is this the prospect for the future?

National Socialism is being fed to you piecemeal. When Representative Dingell of Michigan introduced his National Health Bill this year he showed representatives of the American Medical Association the sections, previously submitted in other years, that were omitted this year as they had *ALREADY BEEN ENACTED!* Beware the emotional appeal that a little socialism is good for a single short-time purpose. The camel's nose is in the tent!

The physicians of Rhode Island will continue to offer the highest quality medical care to every patient regardless of his economic status. We will continue to treat dependents of servicemen the same as any other patient, whether the government pays for them or not.

I am not easily discouraged and I have for many years resisted the attempts of those around us who would steer the course of medicine into socialistic channels. Medicine does not oppose social gains, and is in fact, always promoting and supporting all activities designed to make a better life for all, but we resist regimentation. This becomes more difficult all the time and the prospect for the future seems to be one of either more and more resistance, or complacent capitulation. It devolves, then, upon each and every one of us to be alert, well-informed and critically analytical of all the socio-economic factors which affect us, otherwise the constant attraction by outside forces will destroy the practice of medicine as we know it, and we will be like our British colleagues—mere pawns in a web of restrictions, developed by our own complacence or indifference while we were busily practicing "physic" and letting our medico-economic problem go by default.

In conclusion I want to take this opportunity to thank the many members of the Society who have by their encouragement and active support made my official activities somewhat easier. It is a privilege indeed to serve as president of this august and honorable group of physicians and I am duly and humbly appreciative. It is my sincere hope that my administration has been of benefit to the Society and the profession, as well as advancing, if only ever so slightly, the cause of public health. I am proud to be a member of such an honorable and noble profession and prouder still of the opportunity to serve it to the limit of my ability.

UTERINE CANCER

concluded from page 328

cases of miscellaneous cancers of the genital tract were detected by this survey. Biopsies were recommended on 11 other cases, but these have not yet been received.

4. An increasing number of cases are being examined, and it is expected that information useful to the doctors will be obtained.

ADENOMATOUS POLYPS OF THE GASTRO-INTESTINAL TRACT

FRANCIS P. CATANZARO, M.D., AND ANTHONY MERLINO, M.D.

The Authors. *Francis P. Catanzaro, M.D., Assistant Visiting Physician, St. Joseph's and Our Lady of Fatima hospitals, Providence; Anthony Merlino, M.D., Intern, St. Joseph's Hospital, Providence, Rhode Island.*

ADENOMATOUS POLYPS of the gastro-intestinal tract have been generally accepted as pre-malignant lesions and as such, have become a subject of considerable interest to surgeons and physicians interested in the treatment of this disease. We have surveyed a series of cases treated over the past ten years (1946-1957) at St. Joseph's Hospital. All cases where the gross surgical description and pathological findings were questionable were deleted so that the series, although small, is as accurate as possible. This small number of cases cannot be considered statistically significant in itself, but does follow the statistical pattern in the current literature.

In reviewing this series, we will attempt to demonstrate that the present concept of surgical approach often falls short of adequate treatment for this type of lesion which has such a high malignant potential.

Case Study

This is a summary of forty-nine patients with gastro-intestinal polyps in St. Joseph's Hospital from the year 1946 until March, 1957:

Table I summarizes some of the more important clinical and pathological data in our series of forty-nine patients with gastro-intestinal polyps. From our small series we cannot infer any special predilection for either sex, although twenty-nine of the cases, or fifty-nine per cent, were females.

TABLE I

Age or Sex	No.	%
Men	20	41
Women	29	59
Over 50	25	51
Over 30	43	88
Positive Family History	10	20
Bleeding	32	65

The malignancy age group, that is, over the age of fifty, is the age group in which polyps were most frequently present in this series, slightly over fifty per cent, being more than fifty years of age. Forty-three of the forty-nine patients were more than thirty years of age.

The most frequent and prominent symptom was, as might be expected, rectal bleeding, and the known duration of this symptom ranged from one or two weeks to two years.

The importance of a positive family history of gastro-intestinal malignancy or of polyps is emphasized by the fact that in five of ten cases with a known positive family history, the polyps proved to be malignant, while seven of ten cases with unknown family history also had malignant polyps.

The frequency of polyps of the various sites in the gastro-intestinal tract is summarized in Table II. This shows the rectum to be by far the most common location, sixty-five per cent of the patients in our series having rectal polyps. The two next most common sites are the sigmoid and descending colon, with gastric and ileal polyps somewhat of a rarity. Three of the patients had lesions in more than one site.

TABLE II

Location	No.	%
Rectum	32	65
Sigmoid	11	22
Descending Colon	6	12
Stomach	2	4
Ileum	1	2
Rectum and Sigmoid	1	2
Sigmoid and Descending	2	4

Twenty-five of the forty-nine patients, or more than fifty per cent, had malignant polyps; twelve of thirty-two rectal, eight of ten sigmoidal, and five of six descending colon polyps were malignant; one of the polyps in each of the three patients with lesions in more than one location proved to be malignant.

The value of X ray in the diagnosis of polyps in those locations which cannot be reached by the examining finger is shown by the fact that in all thirteen cases of malignant polyps of the descending and sigmoid colon, the lesion was demonstrated by X ray.

Sigmoidoscopy did not prove nearly as accurate in these same thirteen cases, as only three lesions

continued on next page

were visualized in the nine patients in whom the examination was performed.

The treatment of these polyps, summarized in Table III, can be reduced to excision, resection, and fulguration. In this series of polyps, thirty-four out of forty-nine, or sixty-nine per cent, were

TABLE III

Treatment	No.	%
Excision	34	69
Resection	10	20
Fulguration	3	6
None	2	4

excised, ten were resected, while in only three patients were the lesions fulgurated. Two patients received no treatment. It is interesting to note that nine out of the ten resections were performed for malignant polyps, the tenth one being a gastrectomy for removal of the lone gastric polyp. This means that the remaining sixteen malignant polyps may have received less than adequate treatment; fourteen of these polyps were excised, one was fulgurated, and one was left untreated.

Follow-up was limited only to those with malignant lesions and was possible in all twenty-five cases. There were no ten-year survivors. The longest survival rate was nine years in a patient with a sigmoidal lesion treated by excision. This patient is still alive today. Only seven patients survived five years. The sigmoid colon by a narrow margin proved to be the most favorable site, as three of the seven five-year survivors had sigmoidal lesions, while the other four five-year survivors were equally divided between rectal and descending colon lesions. The average survival rate was 2.9 years for all lesions, longest for sigmoidal (3.6 years), and shortest for descending colon (2.8 years). The average survival rate for those lesions treated by excision was three years as compared to an average survival rate of 2.8 years for resected lesions. This may be misleading, as in most cases the lesions treated by resection were more advanced at the time of surgery. Of the total of twenty-five patients four died of the disease, while two died from some intercurrent condition. Nineteen patients are alive today, fifteen with no signs of disease, and four with malignancy known to be present. Mention should be made of the fact that some of the lesions treated by excision and the patients reported as alive and well today might be classified more correctly as alive with disease, as the histological sections may or may not have been through the base of the lesion at the time of surgery. This fact could not be ascertained from the pathological reports.

One of the patients in this series, reported as alive and well today harbored a benign rectal polyp which was treated by excision in 1949, and which recurred in 1954, this time as an adenocarcinoma treated by abdominal perineal resection. Another patient alive and well today had some rectal polyps excised in 1949 and was then examined with barium enemas, two to three times yearly, for the next two years. In 1951 he underwent an excision of a malignant polyp of the descending colon. These two cases would seem to indicate the importance of periodic follow-up on all patients who have had gastro-intestinal polyps removed, whether they were benign or malignant.

Discussion

The surgical management of these lesions, particularly of those in the colon, has, during the past few years, become a subject of controversy among surgeons. It is our opinion that there is no place for conservatism in the surgical treatment of these pre-malignant lesions.

The adenomatous polyps located in the colon are usually attacked by the surgeon in one of two possible operations. He can do colotomy, coloscopy, polypectomy, and can obtain a frozen section, or he can do a segmental resection together with coloscopy to rule out the presence of other polyps. Regardless of which approach the surgeon prefers, coloscopy should always be done because multiple polyps are present in about thirty-three per cent of the cases. Deddish and Fairweather found polyps other than those shown by X ray in fifty per cent of their cases. Bacon and Peale found a twenty-one per cent X-ray diagnostic error in their series of two hundred and two cases by using coloscopy routinely at the time of laporatomy.

We believe that segmental resection of the colon is the operation of choice in the treatment of adenomatous polyps located in the colon and small bowel. We will endeavor to present several reasons in support of this approach:

(1). The incidence of malignant change in benign adenomatous polyps is fairly common and varies from ten per cent to fifty per cent, according to numerous authors. The distribution of polyps and cancer is similar throughout the colon, and the incidence of age and sex is approximately the same for the two lesions. Moreover, polyps are found in about twenty-five per cent of all colons resected for cancer and usually within a few centimeters of the malignant lesion. These polyps will show microscopically various degrees of change ranging from benignity to invasive cancer. These factors definitely demonstrate the relationship between the two lesions.

(2.) Welch states that local recurrence is very common if there is any microscopic evidence of invasive cancer. This local recurrence presents no problem when the lesion is in reach of the sigmoidoscope; however, when located in the colon, the recurring tumor will escape detection until it

has reached significant size. Visualization by barium enema is difficult, and usually impossible, until the lesion is over one centimeter.

(3.) Gross appearance of the polyp can be deceiving. In 1952 Welch *et al* reviewed three hundred and twenty-two cases of polyps of the rectum and colon that were called benign on gross examination, by both the surgeon and pathologist, and that proved, on microscopic examination, to be malignant. Bacon and Peale reported fifty-one per cent of malignancy in clinically benign cases in which they performed polypectomy. The presence of a peduncle is favorable only to the extent that local recurrence can be prevented by polypectomy, but it does not rule out metastases by tumor emboli. This type of metastasis cannot be ruled out by serial sections through the peduncle. Bacon and Peale cite two instances where the stalk measured two and one-half centimeters and positive epicolic nodes were present in the resected specimens. Scarborough and Klein reported five similar instances.

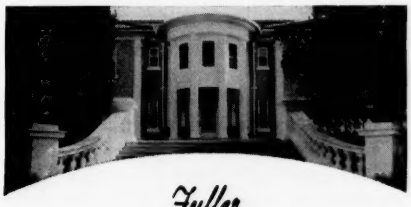
(4.) The limitations of frozen section technique were presented at length by Jennings and Landers, who state that the method is not suitable for papillary tumors of the colon and rectum; histologic diagnosis of the non-invasive type of tumor is also difficult by this method, and, of course, no serial sections are done, so the status of the stalk and base with regard to invasion is still questionable after frozen section.

Considering all these factors, we believe that polyps of the colon should be treated by segmental resection, to prevent local recurrence and to eradicate adequately lymphnode spread. The increased morbidity and mortality associated with this operation, in contrast to that of polypectomy, need not be formidable. Bacon and Peale state that the mortality is four times as high with resection, but their statistics were derived from a group of three hundred and thirty-four cases of carcinoma located from the cecum to the rectosigmoid. This series, obviously, is made up of patients with fairly advanced lesions, presenting various degrees of obstruction, anemia, and chronic debilitation, depending on the extent and duration of their disease. The mortality from segmental resection for colonic polyps should not approach the figure seen with extensive resection for bulky carcinomatous lesions.

SUMMARY

A series of cases of gastro-intestinal polyps is presented, together with some arguments in favor of segmental resection as a more adequate form of surgical therapy, when these adenomatous polyps are located in the colon.

concluded on page 360



THE ROLE OF THE LIBERAL ARTS IN EDUCATION TODAY*

REVEREND WILLIAM R. CLARK, O.P., PH.D.

The Author. *Reverend William R. Clark, O.P., Ph.D., Assistant Dean, Providence College, Providence, Rhode Island.*

THERE ARE, perhaps, as many definitions of "education" as there are persons who have written or spoken about education. Whatever definition you may prefer, this much can be said with truth, that education is concerned with teaching human beings sufficient skills to make a living and sufficient knowledge for a well-rounded intelligent human life.

We could, I suppose, view with alarm the emphasis on specialization in our modern educational plans; but we would be inviting criticism from the advocates of perfection in skills. Yet, it is true, that even in our pursuit of perfection in the natural sciences we are finding more interest in the broadening effect of the liberal arts. Medical schools, for instance, want candidates with a good cultural —humanistic, if you will—background, as well as with talent for the natural sciences. Technical schools and industries where technical skill is important are sending some of their more promising personnel back to the liberal arts for further education. The Bell Telephone Company is an example. For several years it has been running what it calls *The Institute for Humanistic Studies for Executives,* in cooperation with the University of Pennsylvania. In this Institute junior executives have been brought to Philadelphia—together with their families—from all parts of the country to participate in a ten-months' program of liberal arts studies. "A well-trained man knows *how* to answer questions, they reasoned; an educated man knows *what* questions are worth asking. . . . A real education is an emotional experience as well as an intellectual experience." (*Bell Telephone's Experiment in Education,* HARPER'S MAGAZINE, March, 1955.) The directors of the Bell Telephone "experiment" are not yet prepared to make predictions, but the students are pleased with the experience and insist that they have benefited in a very large measure from their "liberal" training. Some critics of this idea insist this is mere "lip service," because it is still the skilled technician rather than the product of broad liberal education who is so much in demand. Whatever statements might be made here and there, this much is admitted to be true: the research experts in science who have come to this country from European universities, where much more emphasis on the liberal arts is given at the college and university level, are leading the American-trained scientists in accomplishments.

*Presented at the Annual Meeting of the Rhode Island Association of Medical Record Librarians, at the Rhode Island Medical Society Library, Providence, Rhode Island, May 1, 1957.

The Dignity of Man

The reason for a well-rounded program of higher education lies in the dignity of man. It is just as simple as that. One of the finest expressions of the dignity of man comes from the Psalmist, David, centuries before the competition between technical skill and liberal education was noticed: "What is man that Thou art mindful of him? or the son of man that Thou visitest him? Thou hast made him a little less than the angels, Thou hast crowned him with glory and honor: and hast set him over the works of Thy hands. Thou hast subjected all things under his feet." (Ps. 8, 5-8) And Shakespeare has the prince of Denmark, Hamlet, say, in one of his numerous soliloquies: "What a piece of work is a man! how noble in reason! how infinite in faculty! in form and moving how express and admirable! in action how like an angel! in apprehension how like a god! the paragon of animals!" (*Hamlet,* Act 2, Sc. 2.)

A realistic view of man reveals in him the presence of an immortal principle of life—the human soul—endowed with two great powers, spiritual like itself, namely, the intellect and the will. The proper activity of the intellect is to know truth; the proper activity of the will is to wish good, that is, to love, to choose, to do, to possess good.

Beneath the intellect and will are arranged lesser powers of cognition and appetition to assist the intellect in learning truth and to carry out the action of the will in doing good. And, since the purpose of liberal education is to develop the entire man, "man as a whole, individually and socially, in the order of nature and in the order of grace," (Pope Pius XI, Encyclical, CHRISTIAN EDUCATION OF YOUTH, par. 14) this means not only the development of the intellect and will but a whole hierarchy of powers with the intellect at the top knowing and

directing, with the will next, trained to will and choose in conformity with the guidance of the intellect. The work of liberal education, then, is to produce a comparatively perfect man, strong all around and sterling in every quality.

There are five intellectual virtues: Art, Science, Prudence, Understanding and Wisdom. Liberal education develops these virtues by means of the curriculum. The curriculum is laid out on a scientific plan which includes all the major fields of culture, because the pursuit of each field trains the mind in one or more of the intellectual virtues, and, since there is some overlapping in the fields, it trains in all of the virtues.

Major Fields of Culture

There are five major fields of culture, since there are five important relations of man to human living. The first of these fields pertains to man's personal relations to others through the expression of his mind and will, through communication, in the beauty of his thoughts and loves and aspirations. It is a noble one, and in liberal culture comprises the field of the fine arts, particularly the most expressive of them which is literature. Naturally, the more one expresses and appreciates beauty in the fine arts the more proficient he becomes in the virtue of art.

Next we would consider the relation of man to the universe around him which is studied in the magnificent array of the natural sciences, extending from the heavens above to the earth beneath and up to man himself. This field is both theoretical and practical. In its applications it contributes to man's personal well-being and comfort. The virtue of science results from study in this field.

In the third place is the relation of man to society—to life with others in its multiple aspects. This constitutes the field of social science. Study in this field engenders the virtue of prudence. But the virtue of prudence stands not only among the intellectual virtues but also at the head of all the moral virtues and it determines the uprightness of their acts. Consequently the main divisions within the social field must receive individual attention so that prudence may be a safe guide for the social actions of the moral virtues. Hence, there is the study of human experience in history, which affects prudence itself. Then, there is the study of the common temporal welfare in political science or government; the common moral good in sociology; the common material good in economics. These studies enlighten prudence in regard to the other moral virtues, justice, fortitude and temperance.

But behind natural and social science and all human expression stands the field of philosophy, which organizes what has been learned in the other fields by offering the fundamental explanation possible through the light of pure reason. Perhaps we might summarize this field in the following manner. Logic trains the mind to obtain truth by means of accurate, deep and discriminate thinking and reasoning. Epistomology studies knowledge itself, evaluates it, and ascertains whether it is really true. Ethics gives a scientific exposition of morals and inculcates the necessity of living a life of moral integrity and high character. These are the normative and critical parts of philosophy. They are elemental in respect to the intellectual and moral virtues. Ontology, or metaphysics, analyzes the very first principles of reality. This is the place in the curriculum where principles as such are studied, and therefore it is ontology especially that trains the mind in the virtue of understanding. Finally, there are the three great divisions into cosmology, psychology, and theodicy, which represent the fundamental explanation and coordinated outlook upon life in respect to the universe, living things—especially man—and God. Those who study well at these deep sources grow in the virtue of true human wisdom.

Man's Relationship to God

To complete the discussion of the intellectual life of man—beyond the field of philosophy there lies the most profound and important field of all, that of theology, the study of God and man's relationship to God. This perfects the work begun in philosophy. It expands and deepens the fund of knowledge far beyond the limits of unaided reason, as brilliant as that might be. It unifies all culture, vitalizes it, interprets it and sublimates it, and directs it to man's eternal destiny. To leave out religion or theology is to render a curriculum essentially unscientific and arbitrarily truncated. Without theology human knowledge remains only a candle in the dark. Without religion culture is vain and depraved, futile and blind; it has lost its purpose and wanders off to its own self-destruction. For truth, good and beauty—light, life and happiness—are found in God; in fact, they are God; and religion unites us to Him. A living understanding of this is Divine Wisdom—the highest quality of cultured minds.

Our age of specialization has been inclined to leave the things of religion exclusively to the dedicated and professional men of religion, assuming that it is a field, like the Holy of Holies, where an unconsecrated dare not enter. As a result, we have matters of material science going along blindly assuming there is no moral implication, no relationship to God or human beings—in a word, pure science. There can no more be pure science without relationship to human beings than there can be theology without relationship to God, because, as we quoted from the Psalmist David, man was placed over all material creation, and it must be for his service and welfare that he use these things.

concluded on page 348

WHAT TO EXPECT IN THE COMING MONTHS*

GEORGE F. LULL, M.D.

The Author. *George F. Lull, M.D., of Chicago, Illinois. Secretary and General Manager of the American Medical Association.*

THE TITLE of this talk may sound as if I were the owner of a crystal ball and had spent some time looking into it. I can assure you that I have no crystal ball, and the observations are deduced from a number of straws in the wind.

The times are changing rapidly, and people and events appear and disappear, so that predictions are dangerous and untrustworthy. I recently read of a meeting that took place at the Edgewater Beach Hotel in Chicago in 1923, that is, about thirty-four years ago. Attending this meeting there were, among others, nine of the world's outstanding financiers:

The president of the largest independent steel company;
The president of the largest utility company;
The president of the largest gas company;
The greatest wheat speculator;
The president of the New York Stock Exchange;
A member of the president's cabinet;
The greatest "bear" in Wall Street;
Head of the world's greatest monopoly;
President of the Bank of International Settlements.

Within twenty-five years let's see what has happened to these men:

The president of the largest independent steel company, Charles Schwab, died a bankrupt and lived on borrowed money for five years before his death. Worth thinking about!
The president of the greatest utility company, Samuel Insull, died a fugitive from justice and penniless in a foreign land.
The president of the largest gas company, Howard Hopson, was insane.
The greatest wheat speculator, Arthur Cutten, died abroad, insolvent.
The president of the New York Stock Exchange, Richard Whitney, has recently been released from Sing Sing Penitentiary.
The member of the president's cabinet, Albert Fall, was pardoned from prison so he could die at home.
The greatest "bear" in Wall Street, Jesse Livermore, died a suicide.
The head of the greatest monopoly, Ivar Krueger, died a suicide.
The president of the Bank of International Settlements, Leon Fraser, died a suicide.

Who at the time of that meeting would have been willing to predict these dire happenings?

Before attempting any prediction it might be well to review with you some of the things that happened to us legislatively in the last Congress and why some of them happened.

Increasing Role of Government

We are all aware of the increasing importance which the federal government has assumed in our daily lives. We are aware of the constantly increasing demand by some, that the federal government solve the problems which beset us as individuals and our local communities. Schools and roads which a generation ago were regarded as local problems have now become the center of great activity in Washington. This results in a tremendous increase in the number of bills considered in Congress each year. For example, more bills were introduced in the last Congress than in any of the preceding ten Congresses (approximately 19,000). The last Congress enacted more Public Laws than any Congress in our history save one. These figures serve to indicate the increasing importance of national legislation as compared to the legislative activities of our states and local communities.

The interest of Congress in matters directly or indirectly affecting the practice of medicine has also been growing. Not only are more bills introduced and more laws enacted, but an ever-increasing percentage of these measures relates to medical practice. Of the 19,000 bills introduced in the last Congress, a total of 571 had primary medical implications, and of these, 25 were enacted into law.

The last Congress considered an ominously wide range of medical measures. They varied from mental health to the construction of medical research

*An Address delivered at the 146th Annual Meeting of the Rhode Island Medical Society, at Providence, Rhode Island, May 2, 1957.

facilities, from the deferment of medical students from military service to appropriations for civil defense medical stock piling; from vocational training of practical nurses and auxiliary hospital personnel to water pollution; from treaties affecting medical licensure to the doctor draft law; from child health and welfare services to the commissioning of osteopaths as medical officers in the Armed Forces; from the Salk vaccine to the national medical library; from the Jenkins-Keogh bills to the medical care of military dependents; from a national morbidity survey to Social Security disability benefits; from narcotic addiction to air pollution. I have not named them all. I have not even named all of the bills on which the American Medical Association presented testimony during the 84th Congress. I believe, however, that I have named enough to give you some idea of the scope of the problem. I would suggest that if you have the time you should read the Annual Reports of the Washington Office of the Association, and the Committee on Legislation for 1956 and look over the compilation of the medical bills introduced in the 84th Congress, which has been prepared by the Washington Office.

Current Congressional Legislation

How about the present session? To date there have been 10,100 bills introduced of which 343 had primary medical implications. Apparently the 84th Congress with 571 medical bills will be surpassed. The 80th Congress (1948-49) had only 220.

For the most part, the health measures introduced thus far deal with: Veterans Medical Benefits, amendments to the Social Security Program, tax deferments for private pension plans or for medical expenses, public health, and studies of, and additional benefits for, the aging.

There are a few old-time favorites and a few new ones in this accumulation which deserve special mention.

As anticipated, a bill has already been introduced (S. 173) by Senator Langer which would change the required age of fifty for cash disability benefits under the recently amended Social Security Act to any age. Of course, we all knew this proposal was coming and it sure didn't take long. In terms of enactment, however, the reduction in age will probably come in easier and slightly more palatable stages. The ultimate result suggested by Senator Langer is, however, probably inevitable unless there is a sharp reappraisal of Social Security legislation in general.

Another bill in the Social Security field which has been introduced before suggests that free hospital benefits be given to all Old Age and Survivors Insurance beneficiaries over age 65. There are over twenty other bills which would authorize various studies dealing with problems of the aging. Only one of these suggests that the present Social Security program be reviewed and re-evaluated.

The Jenkins-Keogh Bills are both back and have the same numbers, H.R. 9 and 10. They are substantially the same as last year with smaller authorized annual deductible amounts allowable for the purchase of private retirement annuities. Since these bills now have the full and complete support of the American Bar Association, chances for passage in this Congress, despite the resulting loss in federal income, although still doubtful, are greatly improved.

As always, there is a large number of bills dealing with veterans' medical benefits. Probably the greatest number of these propose presumptions as to service-connection for various types of diseases and disabilities. Most of these presumptions have no basis in medical fact. Of course, there is still no one in Congress who has introduced a bill which would espouse our position and eliminate the present system of federal responsibility for non-service-connected medical care for veterans and return that responsibility to the individual and the community or state where we believe it rightfully belongs.

There is, however, a bill in the right direction, H.R. 58, which was introduced by Congressman Teague of Texas. This bill would tighten up considerably the administrative procedures for checking on the economic status of a veteran with a non-service-connected disability who claims to the Veterans Administration that he is unable to pay for his own medical care.

The cry continues that the nation's medical resources, especially its manpower, is insufficient to meet the demand for medical care. The House Committee on Interstate Foreign Commerce has held a series of hearings on this subject. The same arguments are being presented that we have heard before—that the medical schools are not producing a sufficient number of physicians, that nurses are in short supply, and that in many specific health fields the deficiency of personnel continues to be acute. The American Medical Association can present an interesting story in this field and among other things call attention to the actual shortage of top-notch student applicants in certain areas, especially in medicine, to the point of scarcity.

One troublesome issue will still be before us next year and that is the conflict between medical schools with full-time clinical teachers and practicing physicians. This also includes certain hospitals whose trustees see no wrong in hiring a salaried staff and making a profit from their services which may be applied against the losses incurred in other departments of their hospital. This situation should be

continued on next page

resolved by the parties concerned and not fought out in the public press.

Cost of Medical Care

The cost of medical care will come in for much discussion, and we should do all we can to dissociate costs of medical care and physicians' fees. The latter have maintained a level consistent with the Consumers Price Index, but hospital charges are rising at a continuing rate of about 5 per cent per year. The best education of the public in this field is the physician himself who, if he were to take time to explain his fees to his patients, the problem would not continue to plague us.

Many factors impinge upon this issue. The role of labor, for example, cannot be overemphasized. To a large extent, the face of medical care in the next few years will reflect the degree to which labor achieves the objectives that it has set. Those objectives have been clearly defined by various labor spokesmen: the promotion of fixed fee schedules throughout the nation, regardless of the income status of the patient, for the purchase of comprehensive benefits, from home and office calls to drugs and all other items included in the maintenance of health or the prevention of disease. These objectives can only raise the cost of medical care because they interfere with the free market in medicine with the operation of a flexible pricing system, and promote mechanisms of financing with inherently high overhead cost. Labor pressure is designed to eliminate the need for personal budgeting and to transfer full responsibility for the financing of health care to third party mechanisms over which labor leaders intend to exercise complete economic and political control. The corporate practice of medicine in its various forms by hospitals or lay-sponsored panels of physicians are all related in one way or another to this question. An urgent public relations need in connection with cost is the preparation and dissemination of convincing arguments that a free competitive market in medicine is best for both the profession and the public.

In one area I believe that conflict is bound to continue on an on again-off again basis. That is in connection with veterans' medical care. Although quiescent during the last year this controversy will undoubtedly erupt again as it has from time to time during the last thirty years. The continued provision of direct federal medical and hospital benefits, by salaried physicians, through tax money, to veterans whose disabilities have no relation whatsoever to military service, will undoubtedly be attacked at intervals in the AMA House of Delegates. Our relations with the American Legion and other veterans' groups, therefore, will tend to be serene or turbulent, depending on the policies enunciated by the association. I foresee recurrent turbulence.

Informing the Membership

One of the greatest problems of organized medicine today is the failure of communications to our members. After spending hours in preparing material and large sums for printing and mailing, we find the majority of our members are still uninformed about vital issues which concern their livelihood and position in a free economy. For instance, in March of this year, 1957, I received a letter from a successful physician, the head of a clinic who told me he had been talking to a lawyer about a scheme of pensions of the self-employed which might come up in Congress. He wanted to know if the A.M.A. had ever heard of it and if we considered it a good thing. All this in the face of editorials, circulars, letters, etc. Evidently, we did not get this across very well.

Now let us consider our communications, or lack of them, as they affect the legislative scene. When the Wagner-Murray-Dingell bill was being considered in Congress, we made an all-out effort from the grass roots up, and we were victorious. Nearly every physician knew the issues and was willing to discuss them anywhere. Beginning in 1952, however, the proponents of compulsory health insurance adopted new tactics. They did not go all out in a frontal attack but adopted a "piecemeal" approach with much success.

During the 84th Congress we had what was considered a "friendly administration." Despite this fact, there were more bills adverse to the private practice of medicine passed in the two-year period than in any other comparable period in our history. Let us ask ourselves how this could happen. Is it possible that our philosophy was wrong? Is our method for commenting on legislation antiquated and ineffective? I believe the answers to these questions is an emphatic "No." I believe that the cause of our present situation is as simple as this. Those individuals and groups whose philosophies vary from ours have increased their activities and their efforts in Washington tremendously. Our efforts have not kept pace. In spite of the fact that we have a small group who have done a very good job, we have not used one tenth of our legislative potential. If we are to succeed, we must make our voices heard back in the grass roots, where the votes come from.

Legislative Summary

I have not given you much of a forecast on specific measures but I will take a chance and tell you what our legislative committee thinks of some of these things:

(a) Federal subsidization of some form of health insurance for government employees. (I

concluded on page 368

The RHODE ISLAND MEDICAL JOURNAL

Owned and Published Monthly by the Rhode Island Medical Society

106 Francis Street, Providence, Rhode Island

THE "TRANQUILIZERS"

Calm by Chemicals vs. Calm by Character

VERY LITTLE IS KNOWN about the mode of action of the phrenotropic agents or "tranquilizers." The term "phrenotropic" means action "on the mind," and it is not strange that a clear understanding of such action is not easy to attain. The end results of long continued use are also still to be determined. It is clear, however, that these substances, like all drugs that have strong and definitive action, have harmful as well as favorable effects of which the physician must be aware. The very fact that their action is "on the mind" is an indication that they will be found most useful in the treatment of mental illness. It is clear that these agents have been of great help to people who suffer from real psychoses and thus to society in general, as they have greatly reduced the number of individuals who have had to be confined to "disturbed" wards in mental hospitals. "Tranquilizers" do indeed afford much needed relief—to sufferers—as do also morphine, alcohol and prefrontal lobotomy—when appropriately applied.

But what of the effect of these drugs on essentially normal people? This is important, because it is such people, in contrast to those who are mentally ill, who, it is estimated, "consume over half the total production of these drugs." "Three out of ten prescriptions in this country are now for 'tranquilizers.'" This type of situation has been repeated over and over again in the case of other new forms of medication, to the great detriment of many people. A therapeutic agent is discovered which has definite and apparently spectacular action, and its striking benefits become known to the laity, often, unfortunately, by means of premature reports, not free from exaggeration, which appear in the public press. The disadvantages and possible damage from its use have not been fully determined, though clinical and laboratory study is being carried on intensively. At this point, because some of its spectacular results have been made known, there is a public demand for it, and physicians who have been deluged by the rosy hued propaganda of some drug houses have been put in a position in which it is difficult to refuse it to patients. Thus, while those who are studying the substance scientifically are most conservative in advising its use, practitioners on the forefront of medical practice are prescribing it with the utmost abandon. This situation has been obtained in the case of adrenal steroids and other hormonal preparations, anti-

continued on next page

biotics, digitalis glycosides and many other most valuable agents. The final place of a new preparation in practical therapeutics is often determined only after the great good that comes from its proper use has been diluted by avoidable harm to individuals.

In a study of 8200 patients who received "tranquilizers" of various makes, Dickel and Dickson[1] found that 400 developed serious untoward reactions related to the skin, liver or gastrointestinal tract. Seventy-two became habituated, and two were so depressed that they committed suicide. These were all apparently normal people—not psychotics, whose main complaint was *anxiety*.

Is anxiety normal? Of course. Should we be subject to emotional tension? Beyond a doubt we should, under appropriate circumstances. Haven't we all noted that the athlete, who is most nervous and "jittery" before competition, often outdoes himself when the contest is under way? It has been well said that "some emotional tension is essential to doing a good job." It is not for nothing that our adrenal cortices and related mechanisms under such tension get us ready to react effectively to stress.

And what of the effect of abnormal calm by chemical agents on character? The boy who "stood on the burning deck whence all but he had fled" cannot be given much credit for bravery if he was filled up with drugs that really made him rather unconcerned about the proximity of the flames. Only recently a Providence physician told of a young girl who came to his office and said: "Doctor, I am on my noon hour and I came to see if you will write me a prescription for Miltown." "Why," said the doctor, "do you want Miltown?" "Because I sometimes get jittery and wish to take something for it," she replied. "But why do you *need* a tranquilizer?" asked the doctor. "Are you smoking too many cigarettes, or drinking too much coffee, or perhaps staying up too late nights?" No answer. When he finally refused her request she said: "I don't see why you won't give it to me. Five or six girls who work with me are taking the medicine, and their doctors write prescriptions for it."

Shall we allow our patients to turn to the tranquilizer every time things get difficult for them? Shall we substitute brain soothers for the courage and determination to face the music and carry through? How will our patients meet emergencies when the pillbox isn't available? Leaning on these drugs is too similar to dependence on the "Dutch Courage" engendered by John Barleycorn, and the result is just as unreliable.

Today's need is for real courage and character, not chemicals, and that type of constant high endeavor indicated in the following lines from *Prayer*, by Untermeyer, which are quoted at the end of a recent article on the subject of psychopharmacology.[2]

> From compromise and things half done
> Keep me with stern and stubborn pride:
> And when, at last, the fight is won
> God, keep me still unsatisfied.

[1]Journal of the A.M.A., Feb. 9, 1957

[2]Drugs for the Soul: The Rise of Psychopharmacology. R. W. Gerard. Science 125:201, Feb. 1, 1957

STATE CYTOLOGY PROGRAM FOR UTERINE CANCER

Published elsewhere in this issue is an important preliminary report from the Rhode Island Women's Cancer Cytology Survey, which is currently in operation under the able direction of Doctor Herbert Fanger and associates. The survey was established primarily as a pilot program to determine under controlled conditions the value of cytological techniques for mass screening purposes. The results presented in this first report are so striking that the reader is urged to peruse them carefully. As a result of the first 2,000 examinations, forty cases (2%) of positive or suspicious genital cancer have been discovered. Twenty-one of these (1% of the whole group) have since been verified by biopsy. This is a significantly higher percentage of positive results than previous studies have indicated. Part of the increase is possibly accounted for by the submission of cervical scrapings as well as aspirated secretions, a more thorough approach than is generally used. One is inclined to infer some weighing of the statistics by inclusion of cases suspected by the attending physician of having cancer, despite the careful warnings of the sponsors that the study is to be directed to patients not suspected of harboring malignant disease. Nevertheless, making full allowance for this possibility, the initial findings are highly evocative.

The general introduction of mass screening by cytological methods has in the past been impeded by a number of difficulties. Technicians trained in interpreting the stained material have been in distinctly short supply. Examination of large numbers of smears is a time-consuming, laborious, tedious and expensive process. Attempts to modify the Papanicolaou technique with a view to reducing the laborious nature of the procedure or to render the specimens amenable to interpretation by individuals untrained in cytological methods have thus far been unavailing. If first impressions engendered by this study are borne out by later reports, such obstacles will of necessity be overcome.

THE LIBERAL ARTS

In this era of specialization in all fields of activity the great role of the liberal arts in education is subject to continuous criticism, and to our regret,

curtailment in the discussion of curricula for the student of today whether he be an undergraduate or a postgraduate. For physicians, education is part of their vocation for their lifetime, and a vital part as the wonders of scientific discovery are revealed.

Therefore, it is with no little pleasure that we welcome to the pages of our Journal the excellent presentation on the role of the liberal arts in education today as given by the associate dean of Providence College, the Reverend William R. Clark, O.P., Ph.D., in his address at our Medical Library on May 1 to the Rhode Island Association of Medical Record Librarians at their annual meeting. We commend the reading of this address by every member of the Society.

We note also, with deep sympathy and regret, the sudden death of Father Clark on the college campus one month after his address to the Record Librarians at our Library. As an educator Father Clark made notable contributions to adult information programs, as well as to the undergraduate curricula at the college. The loss of such clear and sound thinking educators as he is one that our communities can ill afford.

DOCTOR CHASE'S BOOK

(*A Review*)

YOUR WONDERFUL BODY by Peter Pineo Chase, M.D. Prentice Hall, Inc., Englewood Cliffs, N. J. 1957, $5.95

In this vivid, instructive, eminently practical book, happily completed before his lamented death, Peter Chase left us, in part at least, his intellectual autobiography — a unique blend of knowledge, medical and other, together with much advice about the maintenance of health, the whole spiced with the piquant humor indigenous to his native Cape Cod. He tells us that while writing his well-known column *Your Health* in the PROVIDENCE JOURNAL and BULLETIN he acquired much experience in trying to explain to the layman, clearly and concisely, the workings of his body; without this practice he never would have had the "temerity," as he puts it, "to attempt this book." Fortunately for his readers, who should be many, his "temerity" led to the production of a book, original in content and style, altogether unlike any other with which we are acquainted. And to increase the value of the book there are more than seventy illustrations and line drawings which clarify the text and enhance the readers pleasurable enlightenment.

In a series of ten chapters Doctor Chase begins with the beginning; he tells the story of man in the making and ends with reflections on medical philosophy and on growing old, together with some characteristic and comforting allusions to optimism in medicine. There are instructive discussions about child-birth, child raising, the skin, bones and muscles, circulation and blood, digestion, respiration and excretion, the nervous system and sense organs, vitamins and hormones, reproduction and heredity, rest and pain, emotions, drugs, allergies, inflammations, immunity and repair. A formidable array of subjects, to be sure, but Doctor Chase, no lover of Mediterranean words, in simple and easily understandable language, guides you so skillfully from chapter to chapter, that you are scarcely aware he is conducting you through the labyrinthine ways of medicine.

To enjoy the spirit and savor of this book, one must read it; for only so will he appreciate the kindly humor with which Doctor Chase looks upon the foibles and vagaries of his fellow men. He is commenting on the futility of hair tonics for baldness and remarks slyly, "I realize that anything I say will not affect the sale of hair tonics. Years ago, when Dr. Greene's was a popular patent medicine, some exasperated doctor exclaimed that it never did anybody in the world any good. The reply from the manufacturer was: 'You are wrong. It has done Dr. Greene lots of good.' It is not at all unusual for a skin specialist to be bald. Choose your grandparents from those who did not lose their hair." Speaking of soap he counsels "Also remember that although soap is of great medicinal value, 'medicinal soaps' are not worth while. Soap is soap and does its work by cleansing and not by the chemicals that are put in it. If you want a nice smelling soap with perfume, pay the price and have it, but understand that the well-known, inexpensive, mild American brands are as good as money can buy."

Although Doctor Chase wrote with the general reader in mind, nevertheless, so lucid are his descriptions and his comments so wise that physicians too should find YOUR WONDERFUL BODY pleasant reading for their leisure hours.

JOHN E. DONLEY, M.D.

REPORT ON THE ACTIONS OF THE HOUSE OF DELEGATES OF THE AMERICAN MEDICAL ASSOCIATION

at the 106th Annual Meeting, at New York City, June 3-7, 1957

CHARLES J. ASHWORTH, M.D., *Delegate*
ARTHUR E. HARDY, M.D., *Alternate Delegate*

CONSIDERATION of sixty-six resolutions introduced by several states, in addition to many reports from the Board of Trustees, councils, and committees, occupied the House of Delegates of the American Medical Association at its 106th annual meeting.

Priority in importance for members of the Rhode Island Medical Society goes to the Medicare Program because of the position taken by Rhode Island following negotiations with representatives of the Department of Defense.

Medicare Resolved

The House considered three resolutions dealing with the federal government's Medicare program for the dependents of servicemen. The delegates adopted one resolution condemning any payments under the Medicare program "to or on behalf of any resident, fellow, intern or other house officer in similar status who is participating in a training program." Government sanction of such payments, the House declared, would give impetus to the improper corporate practice of medicine by hospitals or other nonmedical bodies. Such proposals, the House added, would violate traditional patterns of American medical practices, seriously aggravate problems of hospital-physician relationships, encourage charges by hospitals for residents' services to patients not under the Medicare program, and create a variety of additional problems in such areas as medical licensure and health insurance.

The House also recommended that the decision on type of contract and whether or not a fee schedule is included in future contract negotiations should be left to individual state determination, restating the A.M.A. contention that: the Dependent Medical Care Act as enacted by Congress does not require fixed fee schedules; the establishment of such schedules would be more expensive than permitting physicians to charge their normal fees, and fixed fee schedules would ultimately disrupt the economics of medical practice.

It was also suggested that the A.M.A. attempt to have existing Medicare regulations amended to incorporate the Association's policy that the practice of anesthesiology, pathology, radiology and physical medicine constitute the practice of medicine, and that fees for services by physicians in these specialties should be paid to the physician rendering the services.

Whether or not future negotiations or renegotiations between the respective states and the Department of Defense will actually result in an indemnity schedule throughout the country, as intended by the action of the House on this matter, remains to be seen. It can be said however, the report of the reference committee that considered Medicare, clearly indicates this to be the intent. The chief reason for lack of complete unanimity on the question apparently arises from the fact that, either by accident or design, the defense department assigned fees for certain services that were so much higher than the average fee charged in certain areas, that these doctors find themselves never having had it so good before, and naturally are strong supporters of Medicare.

Ethics Principles

The long-discussed revision of the Principles of Medical Ethics finally received approval by the delegates at the New York meeting. Presented by the Council on Constitution and Bylaws, and amended by reference committees and discussion on the floor of the house, it now reads as follows:

Preamble

"These principles are intended to aid physicians individually and collectively in maintaining a high level of ethical conduct. They are not laws but standards by which a physician may determine the propriety of his conduct in his relationship with patients, with colleagues, with members of allied professions, and with the public.

"*Section 1.* — The principal objective of the medical profession is to render service to humanity with full respect for the dignity of man. Physicians should merit the confidence of patients entrusted to their care, rendering to each a full measure of service and devotion.

"*Section 2.* — Physicians should strive continually to improve medical knowledge and skill, and should make available to their patients and col-

continued on page 346

REPORT OF A.M.A. DELEGATES

continued from page 344

leagues the benefits of their professional attainments.

"Section 3. — A physician should practice a method of healing founded on a scientific basis; and he should not voluntarily associate professionally with anyone who violates this principle.

"Section 4. — The medical profession should safeguard the public and itself against physicians deficient in moral character or professional competence. Physicians should observe all laws, uphold the dignity and honor of the profession and accept its self-imposed disciplines. They should expose, without hesitation, illegal or unethical conduct of fellow members of the profession.

"Section 5. — A physician may choose whom he will serve. In an emergency, however, he should render service to the best of his ability. Having undertaken the care of a patient, he may not neglect him; and unless he has been discharged he may discontinue his services only after giving adequate notice. He should not solicit patients.

"Section 6. — A physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill or tend to cause a deterioration of the quality of medical care.

"Section 7. — In the practice of medicine a physician should limit the source of his professional income to medical services actually rendered by him, or under his supervision, to his patients. His fee should be commensurate with the services rendered and the patient's ability to pay. He should neither pay nor receive a commission for referral of patients. Drugs, remedies or appliances may be dispensed or supplied by the physician provided it is in the best interests of the patient.

"Section 8. — A physician should seek consultation upon request; in doubtful or difficult cases; or whenever it appears that the quality of medical service may be enhanced thereby.

"Section 9. — A physician may not reveal the confidences entrusted to him in the course of medical attendance, or the deficiencies he may observe in the character of the patients, unless he is required to do so by law or unless it becomes necessary in order to protect the welfare of the individual or of the community.

"Section 10. — The honored ideals of the medical profession imply that the responsibilities of the physician extend not only to the individual, but also to society where these responsibilities deserve his interest and participation in activities which have the purpose of improving both the health and the well-being of the individual and the community."

In approving the new Principles of Medical Ethics, the House of Delegates also reaffirmed the "Guides for Conduct for Physicians in Relationships with Institutions," adopted in 1951, and requested the Board of Trustees to devise and initiate a campaign to educate both physicians and the general public to the dangers inherent in the illegal corporate practice of medicine in its various forms.

Third Party Intervention

The basic issue of third-party intervention, as it affects the patient's free choice of physician and the physician's method of remuneration, was settled when the House adopted the "Suggested Guides to Relationships Between State and County Medical Societies and the United Mine Workers of America Welfare and Retirement Fund," which were submitted by the A.M.A. Committee on Medical Care for Industrial Workers. In approving the guides, the House also recommended that the Board of Trustees study the feasibility and possibility of setting up similar guides for relations with other third-party groups such as management and labor union plans.

The statement, which outlines both medical society and UMWA responsibilities, contains these *General Guides:*

"1. All persons, including the beneficiaries of a third-party medical program such as the UMWA Fund, should have available to them good medical care and should be free to select their own physicians from among those willing and able to render such service.

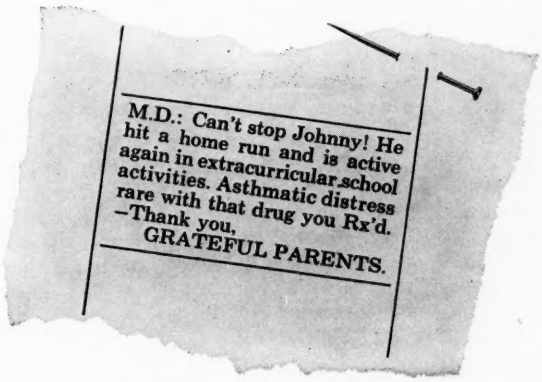
"2. Free choice of physician and hospital by the patient should be preserved:

"a. Every physician duly licensed by the state to practice medicine and surgery should be assumed at the outset to be competent in the field in which he claims to be, unless considered otherwise by his peers.

"b. A physician should accept only such terms or conditions for dispensing his services as will insure his free and complete exercise of independent medical judgment and skill, insure the quality of medical care, and avoid the exploitation of his services for financial profit.

"c. The medical profession does not concede to a third party such as the UMWA Welfare and Retirement Fund in a medical care program the prerogative of passing judgment on the treatment rendered by physicians, including the necessity of hospitalization, length of stay, and the like.

continued on page 348



REPORT OF A.M.A. DELEGATES

continued from page 346

"3. A fee-for-service method of payment for physicians should be maintained except under unusual circumstances. These unusual circumstances shall be determined to exist only after a conference of the liaison committee and representatives of the Fund.

"4. The qualifications of physicians to be on the hospital staff and membership on the hospital staffs is to be determined solely by local hospital staffs and by local governing boards of hospitals."

Social Security for Doctors

Two resolutions favoring compulsory inclusion of physicians in the federal Social Security system and another one calling for a nationwide referendum of A.M.A. members on the issue were rejected by the House. The delegates reaffirmed their opposition to compulsory coverage of physicians under the Old Age and Survivors Insurance provisions of the Social Security Act. They also recommended a strongly stepped-up informational program of education which will reach every member of the Association, explaining the reasons underlying the position of the House of Delegates on this issue. The House at the same time reaffirmed its support of the Jenkins-Keogh Bills.

Officers Elected

Doctor Gunar Gundersen of LaCrosse, Wisconsin, was the unanimous choice for president-elect to succeed Doctor David Allman of Atlantic City, New Jersey who was inaugurated as the 111th president at this meeting. Doctor Gundersen has been a trustee since 1948 and for the past two years was chairman of the board of trustees. He will be installed at the annual meeting next June in San Francisco.

Dr. Tom Douglas Spies, director of the department of metabolism and nutrition at Northwestern University Medical School in Chicago, and a recipient of our Chapin Oration award, received the 1957 Distinguished Service award of the American Medical Association.

Another speaker at a very recent meeting of the Rhode Island Medical Society, Henry Viscardi, Jr., of West Hempstead, New York, founder and president of Abilities, Inc., employing only severely handicapped and disabled persons, became the third layman in A.M.A. history to receive a special award for outstanding service in contributing to the public welfare, and for an outstanding service in advancing the ideals of medicine.

Among other matters acted upon were: "Essentials of an acceptable Medical School," and the "Scope, Objectives and Functions of Occupational Health Programs." Details of these actions will be published presently in the J.A.M.A.

The House further congratulated the Board and the Committee on *Poliomyelitis* for their prompt action in stimulating national interest in the polio immunization program;

Recommended further study and a progressive program of action, probably including legislative changes, to solve the problem of *narcotic addiction;*

Urged a more careful screening of television and radio patent medicine *advertisements;*

Directed the Board of Trustees to investigate the indiscriminate use of stimulants such as *amphetamine,* particularly in relation to athletic programs;

Directed the Speaker to appoint a committee of five House members to study the *Heller Report,* a management survey of the Association's organizational mechanisms;

Commended the Law Department for its special report on *professional liability* and urged state and county medical societies to establish claims prevention programs and to show the new film, "The Doctor Defendant";

Opposed the establishment of any further *veterans'* facilities for the care of non-service-connected illnesses of veterans; and

Condemned the compulsory assessment of medical men and staff members by hospitals in *fund-raising campaigns.*

THE ROLE OF THE LIBERAL ARTS IN EDUCATION TODAY

concluded from page 337

The whole of creation finds its purpose only in the order wherein the lower serves the higher. The mineral world literally feeds the vegetable world; both of these serve the animal world; all three of these lower forms of life serve man; and man, to achieve his perfection, must realize that he too is made to serve a higher power, God and His moral law.

We would not for the world take away the special skills which have been developed by our age of specialization; we have very much of which we can be justly proud. Since the field of knowledge is so extensive, perhaps we need specialists because no one person could become proficient in everything. We must have those who are not merely willing but dedicated to the purpose of learning more and more about less and less. But we must be careful lest the specialist assume that he is the only one in the world when he is likened to the man with a searchlight—the narrower and brighter the beam, the clearer it shows the object on which it is focused, but the more too it throws everything else into darkness.

HOUSE OF DELEGATES
of the
RHODE ISLAND MEDICAL SOCIETY

Report of Meeting Held April 24, 1957

A MEETING of the House of Delegates of the Rhode Island Medical Society was held at the Medical Library, Providence, Rhode Island, on Wednesday, April 24, 1957. The meeting was called to order by the president, Doctor Charles L. Farrell, at 8:15 P.M. The following delegates were in attendance at the meeting:

KENT COUNTY: Russell P. Hager, M.D.; Peter C. Erinakes, M.D.; Edmund T. Hackman, M.D. *NEWPORT COUNTY:* Charles A. Serbst, M.D.; Henry Brownell, M.D. *PAWTUCKET DISTRICT:* Robert C. Hayes, M.D.; Earl F. Kelly, M.D.; Hrad A. Zolmian, M.D. *WASHINGTON COUNTY:* Hartford P. Gongaware, M.D.; James A. McGrath, M.D.; Thomas A. Nestor, M.D. *WOONSOCKET DISTRICT:* Thomas J. Lalor, M.D. *OFFICERS OF THE RIMS:* Charles L. Farrell, M.D.; Joseph C. Johnston, M.D.; George W. Waterman, M.D.; Thomas Perry, Jr., M.D. *PROVIDENCE MEDICAL ASSOCIATION:* Charles J. Ashworth, M.D.; Irving A. Beck, M.D.; Alex M. Burgess, Jr., M.D.; Bertram H. Buxton, Jr., M.D.; Wilfred I. Carney, M.D.; Francis H. Chafee, M.D.; William B. Cohen, M.D.; Michael DiMaio, M.D.; William J. H. Fischer, Jr., M.D.; J. Merrill Gibson, M.D.; Thomas L. Greason, M.D.; Stanley Grzebien, M.D.; John C. Ham, M.D.; Albert H. Jackvony, M.D.; Walter S. Jones, M.D.; Joseph G. McWilliams, M.D.; Arnold Porter, M.D.; William A. Reid, M.D.; Louis A. Sage, M.D.

Also in attendance was John E. Farrell, Sc.D., Executive Secretary.

REPORT OF THE SECRETARY

Doctor Thomas Perry, Jr. read his report, copy of which had been submitted to the members of the House and copy of which is made part of the official minutes of this meeting, as follows:

The Council has held one meeting since the previous session of the House of Delegates. Major actions taken included:

1. The work of the Adult Polio Elimination Committee, headed by Doctor John T. Barrett, was commended for its completeness which attracted national attention to the work of the Society.

2. The appointments of the following committees by the president were approved:

Lions Sight Conservation Committee: Doctors H. Frederick Stephens and Lee G. Sannella.
Delegate to the A.M.A. Medical-Legal Conference: Doctor F. Bruno Agnelli of Westerly.
Delegate to the Maine Medical Meeting: Doctor Stanley Sprague.
Committee to act on the Kent County Resolution adopted by the House in January (re objection to silver nitrate in the eyes of the newborn): Doctors Peter C. H. Erinakes, *Chairman;* John E. Carey of Newport; Alexander Jaworski of Pawtucket, and Nathaniel D. Robinson of Providence.

3. The Council reviewed the appointment of Mutual of Omaha as the fiscal administrator in Rhode Island for the Dependents Medical Care Program, and it authorized the president to send a letter to the membership to inform them of the Society's position in the next program.

4. It voted that a resolution be drafted for presentation to the House of Delegates regarding the certain statements publicizing the Dependents Medical Care Program as set forth in a special leaflet of the Department of Defense distributed to all members of the armed services.

5. It adopted a report of the Board of Trustees relative to improvements and repairs to the Medical Library, and it authorized the expenditure of surplus RHODE ISLAND MEDICAL JOURNAL funds to refurnish the Miller Room of the Library as the executive office, and to provide new equipment for the secretarial staff.

6. It approved of the Ward, Fisher and Company to make a professional audit of the Society's finances.

7. It endorsed in principle the national essay contest of the Association of American Physicians and Surgeons.

8. It referred to the Fee Schedule Committee a request from the U. S. Railroad Retirement Board for information.

9. It reviewed a resolution from the Washington County Medical Society and authorized the president to appoint a committee to evaluate the most effective methods for mass inoculation of the public against diseases, said committee to report with recommendations to the Council.

10. It disapproved the request of the Rhode Island Arthritis and Rheumatism Foundation for endorsement of its state-wide registration of arthritics.

11. It voted that the secretary extend to Doctor Fenwick Taggart of East Greenwich the felicitations of the Society on the occasion of the honoring of him by the citizens of East Greenwich and its environs on Sunday, May 5, 1957.

12. It authorized the executive secretary to represent the Society at a planning committee meeting relative to a coordinated television program to be put on by various health service organizations in Rhode Island on health education subjects.

13. It received notification of the appointment of Doctor William A. Reid by the Board of Trustees of the American Medical Association as the legislative key man for this state.

14. It approved the report of legal counsel relative to the proposed chemical test law for autoists as submitted to the General Assembly.

15. It renamed as the Society's Science Fair Committee the following: Doctors Herman A. Lawson, Irving A. Beck, and John F. W. Gilman.

Doctor Charles Farrell commented on the appointment of the Mutual Benefit Insurance Company of Omaha as the fiscal administrator in Rhode Island for the Medicare Program, on the request for fee schedule information from the United States Railroad Retirement Board, on the Mass Inoculation Study Committee and on the polio vaccine distribution.

ACTION

It was moved that the report of the Secretary as submitted to the House be accepted and approved. The motion was seconded and adopted.

In answer to an inquiry from a member of the House, the president discussed some of the problems that had arisen in the operation of the Dependents' Medical Care Program. He reviewed correspondence between the Society and Major General Robinson, the executive director in charge of the Federal program. He requested that further discussion be deferred until the House took action on the resolution that was to be placed before it.

ELECTION OF OFFICERS FOR 1957-1958

The president called attention to the fact that a ballot prepared by the Council listing nominees for officers and standing committees for 1957-1958 had been submitted in advance to the members of the House. He called attention to the fact that counter-nominations might be submitted by any member of the House for any of the nominees.

There were no counter-nominations.

(*Note: The complete list of Officers and Standing Committees was published in the May, 1957 issue of the R. I. Medical Journal.)

ACTION

It was moved that the slate of nominees for officers and standing committees for 1957-1958* as submitted by the Council be accepted and the Secretary instructed to cast one ballot for the House electing this slate. The motion was seconded and unanimously passed.

RESOLUTION REGARDING DOCTOR FENWICK G. TAGGART

The secretary noted the resolution submitted in the handbook to the House citing Doctor Fenwick G. Taggart of East Greenwich, copy of which is as follows:

Whereas **the Town of East Greenwich and its environs, in order to show appreciation and gratitude for the fifty-three years of professional services rendered to the people of that community by Doctor Fenwick G. Taggart, have declared Sunday, May 5, 1957, as *Doctor Taggart Day,* and**

Whereas **Doctor Taggart has been a member of the Rhode Island Medical Society for nearly fifty years, and has contributed actively to the work of the Society, serving as its Vice President in 1944-45, therefore,**

Be It Resolved **that the House of Delegates of the Rhode Island Medical Society, assembled in meeting on April 24, 1957, extend its sincere congratulations to Doctor Fenwick G. Taggart for his long and devoted service in meeting the medical needs of the residents of his home town, and that it also extend to the citizens of East Greenwich and its environs its appreciation of their recognition of their senior physician in their celebration of *Doctor Taggart Day.***

continued on page 354

for
the first
time

24 HOUR SULFA THERAP

A single dose of KYNEX provides therapeuti
blood levels within the hour. Blood concen
tration peaks are reached within 2 hours
10 mg. per cent blood levels persist beyon
24 hours.[1]

For greater safety: low dosage, high solubilit
and slow excretion help avoid crystalluria
For broad antibacterial effectiveness: KYNE
is particularly efficient in urinary tract infec
tions due to sulfonamide-sensitive organ
isms, including E. coli, Aerobacter aerogenes
paracolon bacilli, streptococci, staphylococci
Gram-negative rods, diphtheroids and Gram

positiv
age of
optimu
patient

Tablets
grains)
24 and

Syrup:
flavore
methox

1. Boger,
Antibiot.

*Reg. U.S. P
LEDERL

P' WITH A SINGLE (1 Gm.) DOSE

positive cocci. **For convenience:** the low dosage of 1 Gm. (2 tablets) per day offers optimum convenience and acceptance to patients.

Tablets: Each tablet contains 0.5 Gm. (7½ grains) of sulfamethoxypyridazine. Bottles of 24 and 100 Tablets.

Syrup: Each teaspoonful (5 cc.) of caramel-flavored syrup contains 250 mg. of sulfamethoxypyridazine. Bottle of 4 fl. oz.

1. Boger, W. P.; Strickland, C. S.; and Gylfe, J. M.: Antibiot. Med. & Clin. Ther. 3:378 (Nov.) 1956.

*

KYNEX

SULFAMETHOXYPYRIDAZINE LEDERLE

*Reg. U.S. Pat. Off.

LEDERLE LABORATORIES DIVISION, AMERICAN CYANAMID COMPANY, PEARL RIVER, NEW YORK

Lederle

HOUSE OF DELEGATES

continued from page 351

ACTION

It was moved that the resolution citing Doctor Fenwick G. Taggart be adopted. The motion was seconded and unanimously adopted.

RESOLUTION RELATIVE TO THE JENKINS-KEOGH TAX DEFERMENT BILLS

The secretary called to the attention of the House the resolution adopted by the Providence Medical Association relative to the Jenkins-Keogh Bills before the Congress, copy of which is as follows:

Whereas **it is universally admitted that tax laws at present discriminate against the self-employed because they grant tax deferment to all officers and employees of a corporation for all payments made by such corporation to a pension plan, and**

Whereas **the Jenkins-Keogh bills, H.R. 9 and H.R. 10, introduced in Congress this year to correct this serious inequity and to permit self-employed persons, including physicians, to enjoy the same tax advantages that are extended to employees under qualified plans established by their employer, and**

Whereas **the enactment of this legislation will contribute to the preservation of the conditions under which independence, private initiative and self-reliance can be fostered by encouraging the self-employed individual to plan his pension and retirement program while he is gainfully employed, therefore**

Be It Resolved, **that the House of Delegates of the Rhode Island Medical Society initiate immediately an active program in Rhode Island to educate its membership, and self-employed persons in general, relative to the Jenkins-Keogh bills, and that it also urge upon the Rhode Island Congressional delegation that it support the measures.**

ACTION

It was moved that the resolution be adopted. The motion was seconded and unanimously passed.

* * *

It was also moved that the members of the Society be notified particularly regarding this resolution and be given the names and addresses of the Rhode Island Congressional Delegation, and urged to write the members of this delegation supporting the legislation. The motion was seconded and adopted.

* * *

RHODE ISLAND PHYSICIAN MEMBERSHIP IN THE A.M.A.

The secretary called to the attention of the House the resolution listed in the handbook relative to the Rhode Island physician membership in the American Medical Association, copy of which is as follows:

Whereas Rhode Island physicians were active in the forming of the American Medical Association, and one, Doctor Usher Parsons, served as its vice-president in 1853, and

Whereas through the years the membership of the nation's ninth oldest state medical association, the Rhode Island Medical Society, has continuously supported in every way the activities and work of the American Medical Association, and

Whereas, at the Seattle Clinical Session of the American Medical Association, in December, 1956, the chairman of the Reference Committee on Reports of the Board of Trustees and the secretary, Doctor Charles Hayden of Massachusetts, did in substance publicly criticize for his committee an alleged failure of a larger number of Rhode Island physicians to be members of the American Medical Association, and

Whereas, in fact 88% of the membership of the Rhode Island Medical Society were members of the American Medical Association as of June 30, 1956, representing one of the highest state memberships on a voluntary basis in the country, therefore,

Be It Resolved, that the Rhode Island Medical Society, through its House of Delegates in meeting on April 24, 1957, do protest the inaccurate and critical report of the physician membership of this state in the American Medical Association as cited in the report to the House of Delegates of the American Medical Association, and as reported in the JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION, January 5, 1957, and do request that the record be corrected accordingly.

ACTION

It was moved that this resolution be adopted. The motion was seconded and passed.

RESOLUTION ON DUES TO THE AMERICAN MEDICAL ASSOCIATION

The secretary called to the attention of the House the resolution submitted relative to the payment of annual dues to the American Medical Association, copy of which is as follows:

Whereas the American Medical Association now has a well established and managed Membership Department which is aided in its work with elaborate tabulating and recording machines for the listing of the membership, and

Whereas each State Medical Association is able to provide the American Medical Association with a roster of its membership corrected as of any specified date,

Therefore, the House of Delegates of the Rhode Island Medical Society recommends that the House of Delegates of the American Medical Association amend Section 2, Chapter III, of its by-laws by deleting the words "to the constituent association for transmittal to the Secretary of," thus leaving the Section to read:

"SECTION 2. METHOD OF PAYMENT. Each active member shall pay the annual dues to the American Medical Association."

ACTION

It was moved that the resolution be adopted.

The motion was seconded and unanimously passed.

RESOLUTION REGARDING DEPENDENTS' MEDICAL CARE PROGRAM

The secretary called to the attention of the House the resolution submitted in the handbook relative to the Dependents' Medical Care Program, copy of which is made part of the official minutes of the meeting.

Whereas the Congress of the United States, in enacting Public Law 569, known as the Dependents Medical Care Act, did intend that beneficiaries of the program might receive said medical care under civilian auspices, and

Whereas the Congress did decree that such civilian medical care, when contracted, "shall be subject to such reasonable limitations, additions, exclusions, definitions, and related provisions as the Secretary of Defense, after consultation with the Secretary of Health, Education and Welfare, may deem appropriate," and

Whereas, neither the Congress nor the Department of Defense have the right under the act to impose their requirements on any physician of any state medical association that has *not* entered into a contract with the Department of Defense to provide medical service under specified conditions, and

Whereas the Office of Armed Forces Information and Education, Department of Defense, in its brochure titled "Medical Care for Service Dependents," distributed to each service member of the armed forces, has stated on page 4 that

"When you seek civilian medical care, ask the doctor whether he has agreed to accept the fee stipulated by the Government as full payment in your case. He should expect you to pay no fees other than those shown on the opposite page (i.e. the first $15 for treatment of injuries outside a hospital, the first $15 of the charges for delivery in a home or office if you are not hospitalized later, costs above $75 for diagnostic tests before hospitalization for physical injury or surgery, or costs above $50 after hospitalization for physical injury or surgery.) IF YOU DO PAY MORE, THE GOVERNMENT WILL PAY *NO* PORTION OF THE BILL."

Therefore, the House of Delegates of the Rhode Island Medical Society records its objection to this Department of Defense statement as being inconsistent with the intent and purpose of the legislation, as being an unwarranted attempt to force physicians to accept a government fee regardless of its adequacy for any given area, as being an unjust attack upon the medical profession by threatening beneficiaries under the program denial of their benefits if they don't demand that the physician accept the governmental allowance, and as being unfair to the physicians who may assist in the program, but not under a contractual arrangement with the federal Government, determining as they have done from time immemorial the patient-physician relationship relative to payments for services rendered, and

Further, the House of Delegates of the Rhode Island Medical Society urges that the House of Delegates of the American Medical Association give due and careful consideration to this objection, and in turn record its disapproval of the literature published by the Department of Defense, as noted in this resolution.

The resolution was discussed at length by members of the House after which the following actions were taken:

1. It was moved that the resolution minus the final paragraph be adopted and a copy of it transmitted to the members of the Rhode Island Congressional Delegation, and to the Department of

continued on next page

Defense. The motion was seconded and unanimously adopted.

2. It was moved that the same resolution with the addition of a final paragraph, which would be amended to read as follows, be included for transmission to the American Medical Association:

***"Further,* the House of Delegates of the Rhode Island Medical Society urges that the Board of Trustees of the American Medical Association give due and careful consideration to this objection and in turn record its disapproval of the literature published by the Department of Defense, as noted in this resolution."**

The motion was seconded and adopted.

MEDICARE DISCUSSION

Members of the House discussed various phases in the development of the Medical Care Program. The President read a communication similar to one which several doctors have already received in which the Executive Director of the Office of the Dependents' Medical Care Program has indicated that his Department has written to the patients of the physicians suggesting that they secure their medical care in the future from other doctors who will be willing to sign the government's claim form accepting the fee allowance as total payment for the service.

ACTION

At the conclusion of the discussion the following actions were taken:

1. That the Society furnish the members with appropriate stickers that may be attached to the claim form of the Dependents' Medical Care Program relative to Item 29, whereby it would be indicated that the physician is certifying Sections A and B of Item 29 under protest. The motion was seconded and adopted.
2. It was moved that a letter from the Society, signed by the President, be prepared in which a strong protest be voiced to the action of Major General Paul I. Robinson, MC, Executive Director of the Office for Dependents' Medical Care, in writing to the patients of Rhode Island physicians stating that the physician's claim would be denied unless Item 29 is properly checked, and advising the patient to be sure that the next physician contacted express his willingness to accept the case under the provisions of the Dependents' Medical Care Program, and further stating that the Society intends to seek legal advice regarding this action, and further that this letter be directed to the Secretary of Defense and a copy of it sent to the Secretary of Health, Education, and Welfare, and to the members of the Rhode Island Congressional Delegation. The motion was seconded and adopted.

EXECUTIVE SESSION

The president announced that the House of Delegates would go into executive session and he turned over the Chair as presiding officer to Doctor Joseph C. Johnston, vice-president.

Upon the completion of the Executive Session, the minutes of which are part of the official records of the Society, the House resumed its regular session to receive reports of Committees.

REPORTS OF COMMITTEES

The secretary noted that the reports of committees had been mimeographed and submitted to the members of the House in their handbook before the meeting.

The president asked for discussion on any of the reports, copy of each of which is made a part of the official minutes of the meeting.

Benevolence Fund

Doctor Arnold Porter suggested that the Trustees of the Fund might consider new methods to secure the participation of every member of the Society as a contributor to the Fund. Other members of the House discussed the possibility of an assessment, or an addition to the dues as a method to secure unanimous support of the Benevolence Fund Program.

ACTION

It was moved that the Trustees of the Benevolence Fund be urged to seek legal advice relative to the advisability and feasibility of an annual assessment or other device for taxing the members of the Society, said assessment or tax to be diverted to the Benevolence Fund, and further that the Trustees be requested to report their findings at the meeting of the House of Delegates in September, 1957. The motion was seconded and adopted.

MENTAL HEALTH COMMITTEE

In addition to the report in the handbook, Doctor Harold Williams submitted the following resolution from the Mental Health Committee:

Whereas the Rhode Island Medical Society has learned with interest that the Butler Health Center is being established and,

Whereas the Rhode Island Medical Society is desirous of cooperating in the establishment of such a mental health center, and

Whereas at the present time the Society has only indefinite knowledge of the plans for the operation of the proposed Center,

Therefore Be It Resolved, that the House of Delegates of the Rhode Island Medical Society hereby directs the President of the Society to communicate with the Board of Trustees of the Butler Health Center and respectfully request from them enlightenment as to the part the Butler Health

continued on page 364

OUR FIRST TEN YEARS*

THE WOMAN'S AUXILIARY TO THE RHODE ISLAND MEDICAL SOCIETY

MRS. HERBERT E. HARRIS AND MRS. CHARLES L. FARRELL

The Authors. *Mrs. Herbert E. Harris of Providence, and Mrs. Charles L. Farrell of Pawtucket, Past Presidents of the Auxiliary to the Rhode Island Medical Society.*

As two of your ten past presidents, we have undertaken the task of giving you some of the highlights of the last ten years of the Woman's Auxiliary to the Rhode Island Medical Society.

If it seems to you that we have given too much emphasis on the early days of our society, it is because we know that period best.

At the risk of repeating what many of you have heard before and thereby boring you, we still thought that possibly to the new members a history of the organization of the Woman's Auxiliary in this state might be of interest.

On February 5, 1947 Doctor Herman C. Pitts, president of the Rhode Island Medical Society, invited all the wives of the doctors belonging to the society to meet at the Library. Ninety-eight women attended the meeting.

Doctor Pitts explained that the House of Delegates of the State Medical Society had authorized him to have a meeting of the County Medical Society presidents to discuss the possibility of having a Woman's Auxiliary.

This group had met and approved the recommendation that an auxiliary be started if the wives of the physicians were interested.

Therefore, Doctor Pitts stated that the meeting of the wives had been called to discuss the matter.

He presented Mrs. James R. Miller of Hartford, past president of the Woman's Auxiliary to the Connecticut Medical Society.

Mrs. Miller gave a most interesting talk about auxiliaries and explained the organization work of a medical auxiliary and spoke of the duties and programs of auxiliaries in general.

After her address and a question and answer period, Doctor Pitts asked the women present if they wished to form a Woman's Auxiliary to the Rhode Island Medical Society.

The vote was unanimous in favor of forming an auxiliary.

Doctor Pitts then announced that a temporary chairman should be elected. He called for nominations.

Mrs. Herbert E. Harris was nominated and elected temporary chairman of the meeting.

Mrs. Harris then called for the nomination of one member from each of the seven medical districts of the state to form a committee. This committee would serve as a board of directors with the officers until such time as the constitution and by-laws of the Auxiliary should be drafted and accepted by the members. It was so voted.

Nominations were made from the floor and the first board of directors was formed as follows:

For Woonsocket—*Mrs. Lorenzo Emidy*
For Pawtucket—*Mrs. Henry J. Hanley*
For Bristol—*Mrs. Arcadie Giura*
For Newport—*Mrs. Alfred Tartaglino*
For Washington—*Mrs. Thomas Nestor*
For Kent—*Mrs. Stanley D. Davies*
For Providence—*Mrs. Thomas J. Dolan*

Mrs. Harris then asked that this committee be allowed to serve as the nominating committee to bring in a slate of officers who should serve until the constitution should be adopted. It was so voted.

The committee retired and later presented in nomination:

For President—*Mrs. Herbert E. Harris*
For Vice President—*Mrs. Guy Wells*
For Secretary—*Mrs. Charles L. Farrell*
For Treasurer—*Mrs. Jesse P. Eddy III*
The above slate was elected.

The meeting then adjourned.

The first luncheon meeting was held May 5, 1947. At that time there were 241 paid members.

At that meeting the constitution and by-laws of the Woman's Auxiliary to the Rhode Island Medical Society were presented and ratified.

The temporary officers and the temporary board of directors were elected for the ensuing year.

On October 5, 1948 two scholarships for nurses of $160 each were established. They were named the Lilian Winsor Harris scholarships in honor of our first president and were to be granted alternately to those hospitals with schools of nursing.

Each succeeding year, two or more scholarships have been granted. The money for them has been raised each year by holding a rummage sale until

*Presented at the Annual Meeting of the Woman's Auxiliary to the Rhode Island Medical Society, at Quonset Naval Air Station, Quonset, Rhode Island, May 2, 1957.

1957. This year scholarship money has been raised by having a successful dessert bridge with Mrs. Richard Haverly as chairman.

During the year 1951, it was voted that in the future the president should be allotted $300 toward her expenses.

In the spring of 1951 the Woonsocket Auxiliary was formed.

During 1951 and 1952 the auxiliary sponsored lectures on socialized medicine with a speaker's bureau of doctors and doctors' wives.

In the fall of 1953 our first dinner-dance was held at the Biltmore Hotel. It was a tremendous success, both socially and financially. In fact it was such a success that a dinner-dance has been held each year.

The additional revenue from these dances has enabled us to give more nurses' scholarships, to contribute generously to the Medical Education Fund and to our Benevolent Fund.

During the past ten years our members have been active in supporting civic and national health projects, etc. Many of our members are leaders in various community projects such as the Red Cross, Crippled Children, Parent-Teacher Associations, and so forth.

Kent County Auxiliary was organized in 1954.

With only two county auxiliaries formed most of our membership consists of members-at-large. Our total membership is 540.

We have shown steady growth during the past ten years under the leadership of our presidents and of the officers serving with them, and of their devoted committee chairmen.

At this tenth anniversary it is fitting to honor the presidents of this auxiliary who have served during these ten years. Namely: Mrs. Herbert E. Harris, Mrs. J. Murray Beardsley, Mrs. William N. Hughes, Mrs. Charles L. Farrell, Mrs. Joseph C. Johnston, Mrs. Banice Feinberg, Mrs. Daniel V. Troppoli, Mrs. Henry E. Utter, Mrs. Patrick A. Durkin, and Mrs. H. Frederick Stephens.

In closing, we give special thanks to Mr. John E. Farrell, executive secretary of the Rhode Island Medical Society, for his patience and ever-ready advice and support.

We trust that at the close of this tenth year, we have become an asset and not a liability to the Rhode Island Medical Society.

Save Saturday, October 19

Annual Auxiliary Dance

at the

Sheraton-Biltmore Hotel

ADENOMATOUS POLYPS OF THE GASTRO-INTESTINAL TRACT

concluded from page 335

References

[1]Welch, C. C.; McKittrick, J. B., and Behringer, G.: Polyps of the Rectum and Colon and Their Relation to Cancer. New Eng. J. Med., 247:959, Dec. 18, 1952

[2]Gastro, A. J.; Ault, G. W., and Smith, R. S.: Adenomatous Polyps of Colon and Rectum. Surg., Gyn., and Obst. 92:164, 1951

[3]Deddish, M. R.: Colostomy and Coloscopy of the Colon Cancer. 6:1021, 1953

[4]Scarborough, R. A., and Klein, R. R.: Polypoid lesions of Colon and Rectum. Amer. Journ. Surg., 76:723, 1948

[5]Bacon, H. E., and Peale, A. R.: Adenomatous Polyps of the Colon, Histopathology and Surgical Management. Ann. Surg. Vol. 144 #1 p 9, 1956

[6]Jennings, E. R., and Landers, J. W.: The Use of Frozen Sections in Cancer Diagnosis. Surg., Gyn., and Obst. 104:60-62, 1957

CITATION TO CHARLES L. FARRELL, M.D.

97th President, The Rhode Island Medical Society

Delivered at the Annual Dinner of the Society, at Providence, Rhode Island, on the occasion of the 146th Annual Meeting, May 2, 1957, by CHARLES J. ASHWORTH, M.D., *Anniversary Chairman*

Honour a physician with the honour due unto him for the uses which ye may have of him.

The skill of the physician shall lift up his head; and in the sight of great men he shall be in admiration.

Then give place to the physician, for the Lord hath created him; let him not go from thee, for thou has need of him.

THESE VERSES from Ecclesiasticus, chapter XXXVIII, of the Old Testament, have no less appropriation this evening than at any prior time. The cultural literature of the ancients, as well as medieval and modern scholars, has bequeathed to us tomes of verse and prose, the purpose of which was achieved by imitating these biblical verses in depicting the physician as a man apart.

Robert Louis Stevenson said: "There are men and classes of men that stand above the common herd; the soldier, the sailor, and the shepherd not infrequently, the physician almost as a rule. He is the flower of our civilization. Generosity he has, such as is possible to those who practise an art — never to those who drive a trade; discretion tested by a hundred secrets, tact tried in a thousand embarrassments, and what are more important, Heraclidan cheerfulness and courage. So it is that he brings air and cheer into the sick room, and often enough, though not so often as he wishes, brings healing." So oft-repeated and aphoristic, is the statement that medicine is both an art and a science. Its modern characterization by Osler, as an art of probability and a science of uncertainty, surely keeps us mindful of its implications, despite medicine's expanding horizons in both the artistic and scientific spheres. In this second half of medicine's greatest century, however, we are constrained to admit that the art has come closer to the endpoint of probability and the science is emerging immeasurably from Oslerian uncertainty.

There are reasons for this progress, but of all that can be enumerated, each can be reduced to a common denominator, *Man, the Physician.*

So true it is that this noble profession of medicine, embraces an almost indescribable variety of personality as well as incalculable and often untapped sources of talent, and occasionally concealed genius. Only time can measure the sum of epithets applied to doctors including as it does, the sublime admonition of St. Luke, "Physician heal thyself," as well as the ridiculous humor of current wags. But tonight we honor a physician, in private practice for more than a quarter of this century, whose dedication and devotion to the progress and advance of medicine, marks him as one of the outstanding reasons why the probability of the art and the uncertainty of the science has lessened. Fortunate indeed is his community, city, and state for the choice of location he made in these plantations, after a professional preparation which included not only medicine, but dentistry and pharmacy as well.

The range and variety in the practice of medicine that your president has experienced in his professional life, almost defies disclosure, extending as it does from the salvage of an infant's life at midnight, in the fourth floor kitchen of a tenement block, to educating our great American public in the middle of the morning, on a nation-wide TV program, about medical economics and doctor-patient relationship in the matter of physicians' charges.

His ascent in the clinical field from a solo practitioner to founder and director of his own clinic in Pawtucket, has been paralleled by a similar rise in the ranks of organized medicine. President of his county medical society, a member of the state board of examiners in licensure in Rhode Island, past president of the American Association of Physicians and Surgeons, past president of the Conference of Presidents, delegate to the American Medical Association, a director of Physicians Service and Blue Cross, and president of the Rhode Island Medical Society, is by no means, an all-inclusive list of Doctor Farrell's activities. His avocations, similarly, have covered wide fields. The theater has provided an area for his participation as an actor, producer, director, and critic. Only a visit to his home could make one appreciative of his artistic ability and skill as a painter. Athletically, though one would not suspect it, he is not only a skier but a skater, having for many years directed the Providence Skating Club. And with the zest of a true *bon vivant,* he has a suitable background for

concluded on next page

the projection of these accomplishments in the lore of extensive travel both at home and abroad.

In this year now ending, the 146th of the Rhode Island Medical Society, many difficult problems have been encountered under the leadership of Charlie Farrell. The trouble with most of us in trying times is that we stop trying, and while chance fights on the side of the prudent, prudence, while keeping us safe, does not always keep us happy.

Decision, as Longfellow once said, can never be recalled, but leadership in medicine as in other endeavors, demands that fearless sterling degree of it that our state society has had the fortunate privilege of enjoying this year.

To no member of the medical profession in Rhode Island does this society owe a greater debt for the devoted enthusiasm, tenacity, and courageous inspiration, he has carried, into, and through his term of office. One of the few among local doctors to perceive the ever mounting importance of the socio-economic aspect of the modern practice of medicine, he has alerted us to maintain a precaution against the many occult dangers, that have, and continue to threaten the dignity and freedom of the medical profession. National recognition of this proclivity is obvious in his choice among seventeen citizens picked from the entire country, to serve as a consultant to the Federal Department of Health, Education, and Welfare, in Washington, for the adjudication of disability problems of the amended Social Security Act.

An English bard, the centenary of whose birth was celebrated in July of last year, was unwittingly prophetic of a plague afflicting American medicine today, the cure or, at least the correction of which, lies in such capable hands throughout the ranks of organized medicine, as those of Doctor Farrell, and for the solution of which there is no antibiotic or wonder drug. George Bernard Shaw, out of a torrent of unjustifiable condemnations of practitioners of medicine in England, either unconsciously, or from an impelling and irresistible impulse, said: "The demands of this poor public are not reasonable, but they are quite simple. It dreads disease and desires to be protected against it. But it is poor, and wants to be protected cheaply. Scientific measures are too hard to understand, too costly, too clearly tending towards a rise in rates. What the public wants therefore, is a cheap magic charm to prevent, and a cheap pill or potion, to cure all disease. It forces all such charms on the doctors."

This isolated sample of the thinking that influenced Great Britain early in this century, is now a legislative and a social specter of our present generation. Just a little over fifty years ago, Grover Cleveland, then President of the United States, said without realizing the path along which history and our socialistic excursions would take us: "A prevalent tendency to disregard the limited mission of this, the President's power and duty, I think should be steadfastly resisted to the end that the lesson should be constantly enforced that though the people support the government, the government should not support the people."

Without minimizing in any sense, the tremendous aid to our national health problems, supplied not only by our profession, but by social, governmental, and insurance agencies, and emanating as it does, from a moral impetus to provide the best medical care for the most, irrespective of social status, our president, Doctor Charles L. Farrell, stands out as a leader against all threats to our system of medical practice as you and I know it.

Doctor Farrell: There are times when experience must bow to reason. While you have never been drowned in renown, or have been worn out with glory, you are now a victim, not an accomplice, I am sure, of the esteem in which your confreres hold you. And I am not unmindful of the honor and privilege that falls to me on this occasion, of presenting you with this traditional memento of the authority you have exercised with such prudence and restraint. Doing easily what others have found difficult is talent, but doing what is seemingly impossible for talent, is genius.

Ladies and gentlemen, may I present an outstanding gentleman — a man who can disagree without being disagreeable — the 97th president of the Rhode Island Medical Society, Doctor Charles Lawrence Farrell.

Meat...

Good Nutrition and the Metabolic Changes of Adolescence

The sharp increase in nutritional requirements during adolescence is ascribed to the rapid growth, restless activity, high basal metabolism, and increased rate of organ development during this period.[1, 2] Nutrient needs during adolescence are higher than at any other period of life[3] except for pregnancy and lactation.

In order to satisfy these extremely high nutritional requirements, "protective" foods supplying liberal amounts of protein, vitamins, and minerals should predominate in adolescent diets.[3] Such foods include meat, poultry, fish, milk, eggs, vegetables and fruits, and whole-grain or enriched cereals and enriched bread. Accessory foods commonly eaten by adolescents to satisfy emotional needs may provide energy, but are commonly responsible for obesity and should not take the place of the "protective" foods.

Meat contributes much toward making the daily meals of adolescents appetizing, ample, and satisfying as well as adequate in protein, B vitamins, iron, phosphorus, potassium, and magnesium. Its complete protein functions in all physiologic mechanisms utilizing protein—tissue growth and replacement, fabrication of enzymes, hormones, and antibodies, and maintenance of the body's fluid balance. Its B vitamins and minerals take part in many processes of intermediate metabolism important in body development.

1. Toverud, K. U.; Stearns, G., and Macy, I. G.: Maternal Nutrition and Child Health. An Interpretative Review, Washington, D.C., National Research Council, National Academy of Sciences, Bull. No. 123, 1950, p. 115.
2. Proudfit, F. T., and Robinson, C. H.: Nutrition and Diet Therapy, ed. 11, New York, The Macmillan Company, 1955, p. 271.
3. Martin, E. A.: Roberts' Nutrition Work with Children, Chicago, The University of Chicago Press, 1954, pp. 231-236.

The nutritional statements made in this advertisement have been reviewed by the Council on Foods and Nutrition of the American Medical Association and found consistent with current authoritative medical opinion.

HOUSE OF DELEGATES

continued from page 356

Center proposes to play in the furtherance of mental health in Rhode Island.

There was discussion of the report.

ACTION

It was moved that the House table the report of the Committee on Mental Health. The motion was seconded and adopted.

* * *

ACTION

It was moved that the House adopt the resolution submitted by the Committee on Mental Health. The motion was seconded and passed.

TRUSTEES

The president called attention to the outstanding work of the Board of Trustees under the chairmanship of Doctor Joseph C. Johnston, citing the many improvements that have been made to the Medical Library during the past year. He commended the Trustees for their outstanding work.

* * *

ACTION ON COMMITTEE REPORTS

It was moved that the following reports as submitted to the House of Delegates be approved and placed on file: Benevolence Fund, Blood Bank Committee, Disaster Committee, Federal Medical Services, Medical Defense and Grievance, Child-School Health, Polio Campaign, Group Professional Liability Insurance, Industrial Health, Board of Trustees of Medical Library, and Veterans' Affairs. The motion was seconded and adopted.

REMARKS OF THE PRESIDENT

Doctor Farrell noted that with the conclusion of this meeting of the House his services as presiding officer would be concluded and he expressed his appreciation of the honor that had been given to him by the Society and the loyalty and support he had received throughout the year from the House of Delegates.

The House applauded the president at the conclusion of his remarks and the meeting was adjourned at 10:40 P.M.

Respectfully submitted,

THOMAS PERRY, JR., M.D., *Secretary*

BENEVOLENCE FUND

During the year the trustees of the Benevolence Fund allocated money from the fund to aid two physicians and their families.

Early this year a second appeal was sent to every member of the Society to contribute to the fund. As the result of this request we have received from 111 doctors a total of $1746.

The total funds on deposit to the Benevolence Fund to this date are $3020.91.

DAVID FREEDMAN, M.D.
HENRY HANLEY, M.D.
GEORGE W. WATERMAN, M.D.

* * *

DISASTER COMMITTEE

Members of the Disaster Committee have participated in two national defense exercises in the past year. Both exercises involved a simulated atomic bomb being dropped in other parts of the United States, as well as New England, and the City of Providence being a designated target area both times. The control center for the various defense units, as well as the medical unit, was competently staffed twenty-four hours a day by fellow members of the Rhode Island Medical Society.

The problems that were encountered were of tremendous proportions and at times discouraging but the manner in which they were handled during the second test as against the first, only helped prove that increasing knowledge and experience in these exercises were most beneficial to all personnel involved.

At the present time representatives of the Disaster Committee are working with representatives of the Civil Defense Emergency Hospital Committee in the apportioning of 200 bed emergency hospitals for the State of Rhode Island.

FRANCIS W. NEVITT, M.D., *Chairman*

* * *

BLOOD BANK COMMITTEE

The Committee filed a detailed report to the House of Delegates for its meeting in January and in this report the activities of the Committee during the previous months were completely described. Since January the Committee has continued its studies relative to arrangements with the Northeast District Clearing House Program. This will take a considerable period of time to complete and it will serve as one of the major projects for the coming year.

HERBERT FANGER, M.D., *Chairman*

* * *

FEDERAL MEDICAL SERVICES COMMITTEE

The only new business to be reported by this Committee is the appointment of Doctor William A. Reid as the "key" legislative representative in Rhode Island. Doctor Reid has kindly accepted this assignment.

ARTHUR E. HARDY, M.D., *Chairman*

* * *

COMMITTEE ON DEFENSE AND GRIEVANCE

During the past year the Committee has consid-

ered twelve cases of grievance and eight of threatened litigation against members of the Society, in which professional liability was alleged. In well over 50% of the grievance cases, the word or act of another doctor has precipitated the complaint. The committee has invariably succeeded in satisfying the complainant.

Court actions, which had all but disappeared last year, have erupted again. The pecuniary motive is paramount in this group. Resentment is very secondary and often absent. There is no cause for alarm but each and every case must be carefully evaluated and regarded as potentially serious.

FRANCIS B. SARGENT, M.D., *Chairman*

* * *

CHILD-SCHOOL HEALTH COMMITTEE AND POLIO COMMITTEE

Many of the activities of your committee this past year have, from necessity, been related to the problem of the Salk vaccine distribution. An "All-Out Polio Elimination Campaign" was instituted in February to encompass all ages and to continue for two months. This campaign was most successful but was hampered in its latter part by a scarcity of vaccine. We hope that when supplies improve all members of the Society will resume their interest and cooperation in making their series available to all people interested in getting their inoculations. It is gratifying to hear that the Rhode Island Medical Society's crusade has been considered one of the best in the country.

We have explored the idea of sponsoring a panel on "Juvenile Delinquency" for professional people in cooperation with the American Academy of Pediatrics, Rhode Island Chapter and the State. Preliminary plans are being worked out by Doctor Herman Marks and Doctor Ruth Appleton for this project.

We have discussed with the local press the possibility of a series of articles stressing Child Safety and Accident Prevention. This, we hope, will appear in the Providence papers at some not too distant date.

Following our evaluation of the medical services of the Providence School Department which was completed last year, we have examined the medical policies of the Warwick School Department with their executives and physicians and find an excellent potential medical service.

Meetings have been held with representatives of the Rhode Island Heart Association, Rhode Island State Department of Health and the United States Public Health Service regarding control and study of an outbreak of streptococcus infection in Rhode Island early in 1957. A letter was sent to all members informing them of the status of the outbreak and outlined suggested treatment.

JOHN T. BARRETT, M.D., *Chairman*

continued on next page

COMMITTEE ON GROUP PROFESSIONAL LIABILITY INSURANCE

A year ago we had 199 doctors insured in our program. $10,610.07 had been collected in premiums and a 15% dividend was distributed to members. There were no underwriting losses.

In the past year we have added 63 doctors and collected a premium of $14,924.10. A 15% dividend will again be paid on May 1, 1957. Underwriting losses by the carrier totaled less than $500. The total premiums collected for our first two years have been $26,534.17 and the underwriting losses under $500. It is naive to expect this ratio to continue. Based on the losses of the years 1949-1953 our rates will be increased this year. In the case of the surgeons the increase will be substantial. This, of course, applies to all companies writing this insurance in Rhode Island and goes along with the situation in the entire country. Only ten states have lower rates than ours.

Anticipating the possibility of severe losses by other carriers we have asked for a special rating for the members in our group. Our carrier takes the stand that we must have at least a membership of 400 and yearly premiums of $40,000 to $50,000 before they will ask the insurance commissioner for a special rate. The committee will continue to work for this objective and in the meantime we must cooperate in trying to recruit at least another 150 members.

FRANCIS B. SARGENT, M.D., *Chairman*

* * *

COMMITTEE ON INDUSTRIAL HEALTH

Several meetings have been held throughout the year. It is pleasing also to report that the attendance of members of the committee and as chairman I express my appreciation to them for their discussions, comments and suggestions.

A brief for the conducting of Annual Physical Examinations of Executives has been prepared and adopted by the Committee for consideration by the House of Delegates.

The Rhode Island Industrial Nurses' Association presented a "Criteria for Employment of Nurses" for approval. As the members of this committee had so many and varied suggestions for revision, a subcommittee of two physicians was appointed. This subcommittee met with a committee from the Rhode Island Industrial Nurses' Association and endeavored to clarify our stand on certain vital points. No further action can be taken until, if, and when such revisions as were suggested have again been presented to us.

The activating of a certain provision of the State Workmen's Compensation Law relating to the diagnosis in relation to back injuries has been tabled, with the thought that it should be the duty of the Advisory Committee to the Commission to clarify and activate such provision.

A *Brief*, regarding the latest in Pesticides and the new federal law which will take most of the danger to the human race out of their use has been submitted.

STANLEY SPRAGUE, M.D., *Chairman*

EXECUTIVE HEALTH EXAMINATIONS

Periodic Executive Examinations

Periodic executive examinations should be encouraged. The benefits to management and the individual are enormous. The physical problems of the aging and the special stresses and strains both physiological and emotional demanded of executives are important criteria for promotion, job stability and the preservation of the individual's health.

Type and Scope of Examination

Because of the variety, types, sizes, etc. of local industry and the cost and ages of the examinees involved, it should be up to the individual Plant Physician to determine the scope and thoroughness of the examination. However, it is felt that each examination should include a complete history and physical examination, rectal, E.K.G., Chest X ray, urinalysis, and blood chemistry.

Examination Results

The consensus of opinion is that (regarding reporting examination results) that the results should be confidential and the physician-patient relationship be retained. In certain cases where conditions were found that would necessitate a disclosure to management, the examinee should be so advised and his permission to so report requested.

It is believed that most executives will take advantage of a periodic health examination on a voluntary basis. It is also felt that promotion or advancement should be preceded by a physical examination. However, if the company policy is such as to require such examination for promotion or advancement, this would not be a matter in which the medical service would be directly involved.

Adopted by the Industrial Health Committee of the Rhode Island Medical Society, January 29, 1957.

* * *

VETERANS' AFFAIRS COMMITTEE

On April 6, 1957 in New York, the eastern regional meeting of the Veterans' Affairs Committees of the American Medical Association was held at which a restatement of the slightly revised policy of the A.M.A. in regard to veterans' medical care was reviewed.

The A.M.A. would like to eliminate non-service connected disabilities from the Veterans' Hospitals. However, this is unrealistic at the present time, but

they would like to eliminate diagnosis as a reason for admission of non-service connected cases—such as neuropsychiatric and tuberculosis. They would prefer to have non-service connected cases admitted on a basis of financial reasons; for instance, a long-term chronic case whose care in a private hospital might result in financial catastrophe.

Their feeling in general, however, is that even these cases could be more successfully treated in civilian facilities locally, which facilities could also more economically be used for the care of non-veteran cases, still partly or wholly at government or state expense and thus eliminate the expensive veterans' medical care of these cases.

They are hopeful that the Teague Bill (HR 58) will pass. This bill in effect requires that the admitting officer of a Veterans' Hospital carefully explain to the veteran the approximate cost of his care for his particular illness in a civilian hospital before he signs the 10 P 10 form stating that he is unable to pay for civilian hospitalization.

They also discussed residency training in Veterans' Hospitals and suggested that at a local level VA staff and consultants be polled as to their opinion of the value of a residency in a VA hospital if only service-connected cases were admitted.

RICHARD P. SEXTON, M.D., *Chairman*

ANNUAL REPORT OF THE BOARD OF TRUSTEES

The trustees of the Medical Library have initiated and with the approval of the Council carried out many needed improvements to the building. In summary the following are the highlights of the work completed or currently authorized for improving the Library:

Janitorial Service

With the retirement of Mr. Comstock, full-time janitor, the trustees engaged the services of the Bay State Window Wash Company to provide janitorial service on a fee basis.

Basement Apartment

The apartment formerly occupied by Mr. Comstock was cleaned, repaired and turned over to the librarian, Mrs. DeJong, and her husband for occupancy.

Library Hours

The daily hours for opening and closing the building were changed to 8:30 A.M. to 4:30 P.M., Mondays through Fridays.

Fire Insurance

The fire insurance coverage has been under review by the trustees. The building has been ap-

concluded on next page

praised by insurance experts, and a new program of coverage is currently being considered.

Exterior Repairs

The sidewalk on Francis Street, damaged by salted sand used during the winter storms by the city, has been repaired.

Basement Improvements

Handrails were installed in the stairwell to the basement. The main basement room is to be used as a committee meeting room, and therefore new lights, new window drapes, and new bookcases are being installed. The Davenport Collection in the Miller Room will be transferred to the new bookcases in the basement meeting room, together with the furniture from the Miller Room.

The Medical Bureau section has been painted. New lights will be installed in the storage room, and the metal stacks from the Miller Room on the first floor will be transferred to the storage room where they will be put to good use.

First Floor Improvements

To complete the floor tiling work started more than a year ago, the lower hall and coat room will be resurfaced in the immediate future. As noted above, the Miller Room will be cleared, and after it is painted it will be refurnished by the Society as an executive office. The book lift in the stacks has been repaired and made usable again.

Second Floor

The two offices in the rear of the auditorium are to be cleaned, and established as the work offices for the Society's secretarial staff, with one room being utilized for the storage of equipment, some of which is currently in the back of the auditorium and on the balcony. A partition between the auditorium proper and the balcony is to be erected this summer.

* * *

The members of the Society have reason to be proud of their Medical Library. We note with interest the costly undertakings in other cities and states of the Medical Association to erect their headquarters building, and we then recognize more clearly how fortunate we are in having our own building, centrally located and well constructed. It is unfortunate that many of the repairs were not undertaken years ago to lessen the present expenses that we face. Nevertheless, we feel that every member can note the fine improvements that have been made in the past few years, and we hope that the Library will be subject to continued improvement in the years ahead.

Respectfully submitted,

JOSEPH C. JOHNSTON, M.D., *Chairman*
BOARD OF TRUSTEES

WHAT TO EXPECT IN THE COMING MONTHS

concluded from page 340

believe a bill will pass.)

(b) Jenkins-Keogh legislation. (Big effort—but passage doubtful.)

(c) Voluntary pooling of risks by private health insurance companies—form of Reinsurance Bill. (I believe it will not pass.)

(d) Reduction of disability age below 50. (May pass at end of Second Session of 85th Congress.)

(e) Free hospitalization for OASI beneficiaries. (Bill will fail.)

(f) Extension of some form of 'Doctor Draft Law." (An amendment to the basic Selective Service Act acceptable to the medical profession will probably pass.)

(g) Increased Medical Research Appropriations. (Congress will probably increase huge sums already included in the administrative budget—despite the fact the Public Health Service is having trouble now getting rid of grant money for this year.)

(h) Bricker Amendment. (Will not pass.)

If we are to live in this changing world we must be aware of the causes of the changes and should they be idealogically unacceptable, we must unite to defeat them before they become part of our social pattern.
